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CONTENTS

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NEWS: Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

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EDITORIAL

KEEPING UP WITH ADVANCES IN MEDICINE

A. EARL WALKER, M.D.*

Medical literature has increased so greatly now that it is impossible for any one physician to read all the current journals, let alone, the new medical books and monographs. Even the abstract services of the journals, cannot cover the entire literature, although the Journal of the American Medical Association does review annually some 1200 periodicals. The regular abstracting journals, such as Excerpta Medica which publishes in 15 sections 14,000 pages of abstracts yearly, are of limited help in keeping up with the literature. This deluge of medical literature is particularly felt by the general practitioner who must follow the advances in almost every branch of medicine. But even the specialist finds it difficult to read the dozens of journals devoted exclusively to his own field. For this reason, one of the functions of a state medical journal is to present the recent advances in all fields of medicine.

It is not a simple matter for a journal to give to its readers a clear picture of the advances in medicine. No doubt the frontiers of medicine are being pushed back by research faster now than in any time in the past, but the insurges are not all advances, some are mere forays, some feints and some really retreats. To be able to recognize the real value of a work appearing in a medical publication requires more than a superficial knowledge of the subject. A well written paper giving adequate details may have such poor controls that the reader is misled by the unwarranted enthusiasm of the writer. But often the paper is not a well presented dissertation but merely a preliminary report based on a few cases followed for two or three months; yet on the basis of this experience the authors strongly advocate a new form of therapy. At times the paper is no more than an announcement of what the author is planning to do and what he hopes may be accomplished. Unfortunately such reports seem to appeal to the lay press which publishes the announcement without sufficiently emphasizing the fact that the new therapy has not been proved to be of value to man. Even more difficult to evaluate are the reports which appear primarily in the newspapers or magazines written by "science" writers announcing a new discovery or therapeutic procedure. Such articles, couched in non-medical terms, cannot be critically assayed, are usually premature and over-enthusiastic. But despairing patients seize upon these stories, as a drowning man grasps a straw, and besiege their physicians begging to get this new panacea which they have read about in the press.

* Member of the Editorial Board, Maryland State Medical Journal.

While it is the purpose of a state medical journal to keep its readers in touch with the latest developments in all fields, the announcements must be of proved surgical procedures or medical therapeusis. The general practitioner does not have the time, facilities nor background to evaluate experimental procedures. Only the large medical centers are so equipped to safeguard the patient while a new drug or operation is being studied. Patients desiring the benefit of the most recent research techniques of medicine should be sent to such centers. Only when the development has been proved to be of value and its inherent dangers are known—and this may take several years—is it to be used in general practice. This Medical Journal will endeavor to keep its readers acquainted with the latest approved triumphs of medicine so that the health of the state may be maintained at the highest possible level.

YOUR ANNUAL MEETING

BEVERLEY C. COMPTON, M.D.*

On Tuesday, April 28 and Wednesday, April 29, 1953 your Annual Meeting will take place in a somewhat revised form. There are to be papers limited to twenty minutes from 9:30 a.m. until noon, and from 2:00 p.m. to 4:40 p.m. on both days. The evening meetings will follow the usual form of recent years, with a meeting on Tuesday night, including the President's address, and a meeting on Wednesday night following the buffet supper. A record attendance is anticipated.

The following is a list of speakers and the times allotted. Topics have been withheld and will appear in the next issue of this Journal.

Tuesday, April 28, 1953

9:30 a.m. Theodore E. Woodward, M.D.
9:50 a.m. Philip F. Wagley, M.D.
10:10 a.m. Henry T. Bahnson, M.D.
10:30 a.m. Howard W. Jones, Jr., M.D.
11:00 a.m. Robert P. Glover, M.D.
11:20 a.m. Harry M. Robinson, Jr., M.D.
11:40 a.m. Henry G. Reeves, Jr., M.D.
2:00 p.m. John G. Wiswell, M.D.
2:20 p.m. I. William Nachlas, M.D.
2:40 p.m. J. Mason Hundley, Jr., M.D.
3:10 p.m. Thaddeus S. Danowski, M.D. (Harvey Grant Beck Memorial Lectureship.)
3:40 p.m. John Huff Morrison, M.D.
4:00 p.m. Erwin R. Jennings, M.D.
4:20 p.m. George G. Finney, M.D.

On Tuesday evening Dr. Maurice C. Pincoffs will give his Presidential Address. This will be followed by the John M. T. Finney Fund Lecture given by Dr. Robert R. Linton of the Surgical Department of the Massachusetts General Hospital in Boston.

Wednesday, April 29, 1953

9:30 a.m. Milton S. Sacks, M.D.
9:50 a.m. Israel Zeligman, M.D.
10:10 a.m. Gordon E. Gibbs, M.D.
10:30 a.m. William S. Love, M.D.
11:00 a.m. R Adams Cowley, M.D.
11:20 a.m. Philip A. Tumulty, M.D.
11:40 a.m. Noel E. Foss, Ph.D.
12:30 p.m. Louis H. Bauer, M.D., President, American Medical Association, Guest Speaker at Woman's Auxiliary Luncheon, Sheraton Belvedere Hotel. Everyone is urged to attend.
2:30 p.m. David Bodian, M.D.
2:50 p.m. Ruth W. Baldwin, M.D.
3:10 p.m. E. Converse Peirce, M.D.
3:40 p.m. James P. Miller, M.D.
4:10 p.m. Frank G. MacMurray, M.D.
4:30 p.m. Lawrence R. Wharton, M.D.

*Chairman, Committee on Scientific Work and Arrangements.

On Wednesday evening there will be a buffet supper followed by a general meeting at which Dr. John S. L. Browne of McGill University, Montreal, will give the Isaac Ridgeway Trimble Fund Lecture.

BUSINESS MEETINGS

Council—1211 Cathedral Street

Monday, April 27, 1953, 11:00 A.M.
Tuesday, April 28, 1953, 1:30 P.M.

House of Delegates—1212 Cathedral Street (Deutsches Haus)

Monday, April 27, 1953, 2:00 P.M.
Tuesday, April 28, 1953, 2:00 P.M.
Wednesday, April 29, 1953, 9:30 A.M.

HONOR TO DR. LEWIS K. WOODWARD

Dr. and Mrs. Lewis K. Woodward, Sr., of Westminster will be Maryland's guests of honor at the First Western Hemisphere Conference of the World Medical Association, to be held in Richmond, April 23 to 25, 1953, in observance of the lengthening of life and the constant improvement of human health.

Governor Theodore R. McKeldin of Maryland, in a message received here, told Governor John S. Battle of Virginia of the selection, adding that Dr. and Mrs. Woodward are looking forward to attending the conference. Recently Governor Battle asked each of his 47 fellow-Governors to appoint a physician who will reach the age of 75 during 1953 to visit Virginia and tell of medical advances that have taken place during his lifetime. The invitation included the physician's wife.

Dr. Woodward has been in general practice since 1899. He was born in 1878, the year when pioneering Robert Koch published a history-making treatise on causes of infection, opening the way to rapid progress in various fields of medicine. Dr. Woodward was graduated from the Hahnemann Medical College and Hospital of Philadelphia in 1899 and was licensed the same year.

At the Richmond conference, guests will be greeted by Dr. Louis H. Bauer, president of the American Medical Association, and by leaders of Latin American Medical Societies. Besides scientific sessions, there will be opportunities for visiting historic sites in Virginia, including the 18th century Williamsburg restoration. Expenses of the conference, and of guests and delegates, are covered through a grant by A. H. Robins Co., Inc., ethical pharmaceutical house founded in Richmond 75 years ago this year.—*Arrangements Committee, Diamond Anniversary of Medical Progress, Suite 3201, 444 Madison Avenue, New York 22, N. Y.*

Scientific Papers

SYMPOSIUM ON THE TUBERCULOSIS PROBLEM IN BALTIMORE—PAST, PRESENT AND FUTURE*,[1]

JOHN T. BARNWELL, M.D., *Moderator*[2]

DR. MOSES S. SHILING, PRESIDING: . . . We had several choices when deliberating about a topic for this general meeting. We could have picked such subjects as arteriovenous aneurysm, pulmonary adenomatosis or histoplasmosis. True, these make for most interesting discussions but we all felt that a panel on Tuberculosis as it affects a practitioner, the specialist, and the various collateral branches of medicine, would still be in order.

We have known the etiology of Tuberculosis for over fifty years and every graduate of the School of Public Health can outline a beautiful and effective plan for Tuberculosis control, and in recent years we have had available bacteriostatic drugs, yet with all this it is still possible for an individual in this day and age, to seek medical attention and not have his Tuberculosis diagnosed until it has reached a far advanced stage, making recovery unlikely. For this reason we have called together representatives of the various groups that have to do with Tuberculosis and have asked them to present to us and perhaps to defend their programs, attitudes and hopes for the future.

At the end of their presentation there will be a question period and I trust you will all send your questions forward. At the end of each row of seats there are little notebooks to use. Send your questions to the center and forward and Dr. Beacham will submit them here. To tie all together, we are fortunate to have as a moderator, Dr. John T. Barnwell, head of the Tuberculosis Division, to the Veterans Administration.

Dr. Barnwell has a distinguished career as an investigator, teacher, and in recent years administrator of a nation-wide group of Tuberculosis Facilities in Veterans Administration Hospitals. This organization has set a pattern for combining medical care and research that could well be emulated by Sanatoria on a state and local level. It is with a great deal of pride that I now turn the meeting over to Dr. John T. Barnwell.

INTRODUCTION. DR. BARNWELL: Thank you, Dr. Shiling. You will note that my career did not include any experiences as a moderator. I am not quite sure what my job is; I have never participated in a meeting that quite looked like this on paper before. It reminds me of some meetings we used to hold in Michigan before even a smaller number than this where we did these programs of washing our linen in public. When we get to some of the questions that have already been passed up, I think the panel will have realized what it was facing this afternoon. There are eleven people on the panel and I think you know them all better than I do. We are to start with Dr. Charlotte Silverman, Director of the Bureau of Tuberculosis, City Health Department, Baltimore.

THE ROLE OF THE HEALTH DEPARTMENT

CHARLOTTE SILVERMAN, M.D.[3]

The Bureau of Tuberculosis of the Baltimore City Health Department, the official agency charged with conducting a control program in this city, has been faced with an enormous problem for many years. While it is true that any large city, by its very urban characteristics, is more fertile ground for tubercle bacilli than sparsely populated rural sections, Baltimore has

* The Editor wishes to thank Dr. E. G. Beacham for his assistance in the preparation and editing of these papers.

[1] Presented on Wednesday afternoon, April 30, 1952, at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland.

[2] Chief, Tuberculosis Division, Veterans Administration, Washington, D. C.

[3] Director, Bureau of Tuberculosis, Baltimore City Health Department.

outstripped the other major cities of this country by having the highest mortality rate of them all for a number of years. In this city of approximately one million residents of whom more than one third live in substandard homes, and of whom 24% are Negroes whose opportunities for decent living are infinitely poorer and among whom tuberculosis mortality is four to five times greater than in white residents, our tuberculosis control activities have been similar to those in other communities with perhaps a few additional features.

Our first function is to accept reports from private physicians, chest clinics, general hospitals and other agencies for persons who have tuberculosis. What proportion of *all* cases of tuberculosis developing each year is represented in the 1400 new cases reported to us annually is not known. But, certainly, we can say that the greater the services rendered to doctors and to their tuberculous patients by the official agencies, the more intense the inducement to physicians to search for tuberculosis and to share knowledge of their cases with the Health Department. When, for example, the Henryton State Tuberculosis Hospital was opened twenty-nine years ago, a considerable increase in reported tuberculosis in Negroes in Maryland was observed.

For the diagnosis of pulmonary tuberculosis, the City Health Department provides the services of four chest clinics in various parts of town. These clinics hold sessions daily, each one of them having one or two evening sessions a week for the convenience of employed persons. Any physician may make referral of his patients to these clinics where chest X-rays, tuberculin tests, and examinations of sputum or stomach washings will be done as indicated and results reported to the referring doctor. These clinics offer follow-up examinations and pneumotherapy for those diagnosed as tuberculous who are without personal physician and who generally have had a period of sanatorium care. Although the practicing physician plays an important role in the initial suspicion or diagnosis of tuberculosis, he has much less to do with the subsequent care of tuberculous persons.

The search for new cases of tuberculosis is a considerable activity of the Health Department. It involves the traditional examining of associates of known cases and the newer means of screening large groups of the general population and the general hospital population. Regarding the investigation of tuberculosis contacts, children have for years constituted too large a proportion of those examined. Of all the tuberculosis cases reported among white residents of Baltimore, only 2.5% occurred in children under fifteen years of age, and yet, children formed more than one third of the total number of contacts examined in our clinics. Negro children, among whom 18% of all tuberculosis in this race was found, comprised 40% of the contacts examined.

Tuberculosis is nowadays primarily a disease of adults, and more than that, an ailment which strikes males past 35 years of age in the greatest number. Yet it is common experience for grown men to offer the greatest resistance to examination because they think it unimportant or are too busy. We shall be much more successful in our search for unknown tuberculosis if adult men can be persuaded that they are at risk from this disease.

In Baltimore for the past few years, over 100,000 persons or 10% of the population have each year received small chest X-rays in mass case finding programs. The City Health Department, with the assistance of the Maryland Tuberculosis Association, yearly takes chest microfilms of about 50,000 persons in industries, communities and schools. Among each 1,000 persons X-rayed, there are found two to three new cases of tuberculosis which are of clinical significance. At *no* time has there been any significant *difference* in the findings *among white and Negro persons X-rayed*, despite the fact that Negroes experience a mortality rate from tuberculosis four to five times greater than that among white persons, and a *much higher morbidity rate*.

The three largest general hospitals in this city

have been equipped with photofluorographic units which are used to X-ray the chests of new dispensary patients, old clinic patients on indication, medical, nursing and other hospital personnel. Over 35,000 examinations of this kind are made annually. The Eastern and Southern Health District Buildings of the Health Department are equipped with small film X-ray units which are available for screening purposes, and the Maryland Tuberculosis Association in its central office took over 13,000 X-rays last year as a case finding project.

Once discovered, tuberculosis presents a formidable treatment problem in this community. For too long, we have had only half as many sanatorium beds as are needed in Maryland. Worse still, tuberculous Negroes have had available to them less than one bed for each annual death which is far below the minimum standard of 2.5 beds. Ironically, this critical shortage of beds has been aggravated by improved methods of therapy for tuberculosis. Chemotherapy, improved surgical techniques, expanding social service and occupational and diversional activities have led to more successful treatment, fewer fatalities, fewer irregular discharges, and consequently, fewer vacancies in the sanatoria—with mounting waiting lists.

Because of fearfully long delays in hospital admissions, increasing use of antibiotics for home treatment has been noticeable since the advent of streptomycin and para-aminosalicylic acid. Chest physicians have treated many of their private patients in this way; chest dispensaries in several general hospitals have been prescribing streptomycin and PAS for many patients whom they are following. Clients of the Health Department's Medical Care Program who are found to have tuberculosis are allowed these drugs for home treatment while awaiting sanatorium admission. The public health nurses of the Baltimore City Health Department play a major role in these instances, since in the majority of cases they are called upon to administer the streptomycin injections, or, if possible, instruct an educable member of the family.

The Bureau of Tuberculosis is of the opinion that the discovery of drugs useful in the control of a communicable disease which is a hazard to the public health, casts a new responsibility upon an official agency. Just as the Bureau of Venereal Diseases has made available penicillin and other drugs for the treatment and prevention of spread of venereal diseases, so should the Tuberculosis Bureau be prepared to offer medications to suitable cases who are unable to purchase them and who are many months from possible hospital admission. With this in mind, but with no available appropriations, the bureau put aside a small sum from its regular budget for the purchase of streptomycin and PAS. Since January of this year, it has been possible to put approximately thirty patients, largely from our own chest clinics, on these drugs while they await hospital admission. All of the patients are Negro, since they are likely to suffer the most rapid fatal extension of disease and all were selected on the basis of type of lesion, home situation, and willingness to cooperate. These patients take rest in bed at home and are visited twice weekly by our public health nurses who administer 1 gram streptomycin intramuscularly each time. For each patient, 12 grams of PAS is prescribed daily. It is too soon to speak of results. We have, to date, lost several patients whose disease progressed inexorably in a very brief period of time. Others are clinically improved without X-ray betterment, and still others have shown the most encouraging responses. An eighteen year old Negro boy with massive bilateral bronchogenic spread from a cavity in the right upper lobe and severe toxemia is, after three months of therapy, not only alive but symptom free and now showing beginning resolution of his lesions on X-ray. This boy could not have survived his waiting period of hospitalization without chemotherapy. We are hopeful of being granted increased funds for drug therapy next year.

The grave hospital situation has led to the institution of another procedure to help avoid incurable illness or death. For several years, the Bureau of Tuberculosis has recommended a lim-

ited number of patients for direct surgical admission, generally to the Baltimore City Hospitals. Medical abstracts and complete sets of chest films have been sent to the hospital for consideration by the medical and surgical staffs. If agreement is reached, the patients are admitted for lucite ball plombage, thoracoplasty, induction of pneumothorax, etc. This procedure can be employed for comparatively few patients, since even if they are good surgical candidates, they come from poor homes where proper convalescence is not feasible and successful completion of treatment would involve transfer to the Tuberculosis Division.

It is good to report that the end of this year will bring to Maryland new hospital beds which should help appreciably to improve the treatment of the tuberculous. New wings at the Baltimore City Hospitals and Mt. Wilson State Hospital, as well as the new Veterans Administration Facility, will open by the end of this year.

The restoration of the tuberculous to useful living in the community is a vital part of our control program. The Bureau works very closely with the Vocational Rehabilitation Division of the Department of Education in planning for the training and job placement of the tuberculous whose disease is under control. Vocational Rehabilitation does a fine job in a difficult situation, especially difficult with respect to Negroes for whom job opportunities are scarce except for laboring work.

Finally, I wish to comment on our use of BCG vaccine against tuberculosis. We believe that although many questions about this vaccine are as yet unanswered, its value has been demonstrated as an important adjunct to a tuberculosis control program, particularly for persons who may face unusual risk from tuberculosis. We have held regular BCG clinics at the Eastern Health District since October, 1949, vaccinating uninfected contacts of known cases, nurses, medical students and other hospital personnel. As of November, 1950, the Bureau of Tuberculosis and the Harriet Lane Home inaugurated a continuous program of vaccinating all Negro babies born at the Johns Hopkins Hospital. With parental consent, these babies receive BCG before they leave the hospital. Last year more than 1,000 infants were vaccinated. In late 1950, several hundred Negro adolescents in vocational high schools received the vaccine after preliminary screening with tuberculin tests. We hope to be able to resume this program this year.

The outlook for the management of this chronic contagious relapsing disease is better now than it has ever been in this community. With the certainty of expanded institutional facilities in the near future, and the prospect of new improved drug therapy in the form of the isonicotinic acid hydrazide, medical and surgical treatment will be offered more widely and more successfully. Tuberculosis is, however, a disease with deep social and economic roots as well. To implement our medical advances, steps must also be taken to alleviate poverty, slum housing, and the inequities of segregation. A double-pronged attack against this disease is necessary.

DR. BARNWELL: Thank you, Dr. Silverman, and on time, too. I suppose all members of the Panel know they have been given a definite time limit. As Dr. Shiling told you, the questions will be taken up and discussion will be had at the end of the papers by the Panel members. I want to take this opportunity to tell you that Dr. Shiling did a most remarkable job in having every member of this panel turn in a written statement beforehand, which he has timed and I have the time here. Although the questions will come later, Dr. Silverman, I hope you will remember that you can take up one matter that struck me in your paper, it was your distinction between X-ray incidence and morbidity by rays.

Now, the next paper is by Dr. Nathan Racusin, Practicing Physician in Baltimore, and the title of this paper is: "Tuberculosis As Seen By the General Practitioner."

TUBERCULOSIS AS SEEN BY THE GENERAL PRACTITIONER

NATHAN RACUSIN, M.D.

To miss the early diagnosis of an acute abdomen endangers the life of one individual, but only one; to overlook the active case of tuberculosis may endanger an entire family along with an unknown number of contacts. The further tuberculosis progresses also the more severe is the economic impact on the patient and his family when the presence of the disease is finally discovered.

The general practitioner sees in addition to the as yet undiagnosed cases, patients with all varieties and in all stages of tuberculosis. As contrasted with conditions as they commonly existed in the short span of eighteen years ago, it is my belief that we no longer see much active far-advanced tuberculosis in ambulatory patients.

Because of the frequently almost or altogether asymptomatic character of the early stages of certain diseases, notably tuberculosis, syphilis, and diabetes mellitus, routine chest X-rays, STS and urinalysis have over the years been rewarding to the patient and the practicing physician by bringing to light these serious organic diseases.

Factually speaking, in a city like Baltimore with well staffed tuberculosis clinics and Health Department laboratories, the only thing usually necessary for the practicing physician to do is suspect the possible presence of the disease. From there on the diagnosis is almost always made without the necessity of his further intervention on the basis of serial X-rays, sputum examinations, gastric washings and animal inoculation.

Having been a member of the team that diagnosed the active tuberculosis, the physician then has to explain tactfully and honestly and convincingly to the patient and the family the nature of the illness; and to point out the desirability of early specialized treatment, preferably in a sanatorium. At the same time arrangement is made for examination of contacts.

An interesting side light on the present "tuberculosis consciousness" of the public is the increasing frequency with which casual contacts (such as fellow workers) of recently diagnosed cases come to the physician, fearing that they may have contacted the disease.

The part that is played by the general practitioner dealing with tuberculosis concerns, first, the eternal suspicion of its presence in all patients; second, the practice of securing chest X-rays, and where indicated, laboratory studies; third, the removal whenever possible of all active cases to a sanatorium or tuberculosis hospital for definitive treatment; and fourth, the periodic re-checking of close contacts, and all cases believed to be inactive.

In recent years there has been a definite change in the attitude notably of the younger generation toward tuberculosis. The change has been mainly due to continuing education of the public emphasizing the importance of early recognition of the disease.

Instead of the traditional "horse in the burning barn" attitude formerly exhibited by patients with the disease, the majority of those with active disease are now eager to get started with treatment.

Perhaps with the further investigation of substances that show promise in treating tuberculosis the general practitioner may at some future time assume a more active role in treating tuberculosis. But at present, the better advice to those individuals with active disease seems to be "get to a sanitorium as soon as you can."

DR. BARNWELL: Dr. Racusin, I hope when it gets to your name and the discussion later, that you will be willing to discuss the possibility of reports of routine X-rays on the paying customers that go to private physicians. All the reports I know of are on institutional groups which contain large percentages of indigent patients. I'd very much like to know how many undiagnosed cases do escape the routines of the private practitioner when dealing with paying customers.

The next paper is by Mrs. Anita Henson, Public Health Nurse in Tuberculosis Control, Public Health Department, City of Baltimore.

THE PUBLIC HEALTH NURSE IN TUBERCULOSIS CONTROL

MRS. ANITA HENSON[4]

The purpose of the home visit in tuberculosis is for the public health nurse to impart sufficient knowledge about the disease so that the patient and family can act intelligently in care and prevention. In order to be a successful teacher, though, the nurse needs to be informed regarding epidemiology, pre-disposing factors, types and classifications of tuberculosis.

The general functions of the public health nurse in the TB Control Program are to help the family physician or the health department clinic doctor educate the people toward healthy attitudes on tuberculosis and to help make the community, Chest X-ray conscious.

Her functions in the home are to help interpret the diagnosis after it has been presented by the physician-in-charge; to help establish isolation, where indicated; to help set up a simple routine for care and treatment while plans are being made for the hospitalization of the patient; to assist the family make the necessary social and economic adjustments and to help plan for the examination of contacts.

It is the public health nurse who usually notifies the patient when a sanitorium bed is available and she frequently helps arrange for transportation.

During the period of hospitalization, the public health nurse keeps in contact with the patient through communications to the institution and through periodic home visits to the family. During these home visits she encourages the relatives to keep the patient a member of the family unit by writing to him, visiting him and discussing developments at home with him. She also supervises the health and economic security of the family and helps prepare them to receive the patient, without fear of his being a menace on his proper discharge from the hospital.

Because the public health nurse realizes that adequate diet and rest are most important factors in tuberculosis control, she often feels frustrated in her efforts. In every family there are economic problems, of varying proportions, associated with tuberculosis. Poverty engenders crowding, ignorance, nutritional deficiencies and medical neglect; all of which create a favorable soil for the tubercle bacillus.

Poor or substandard housing is occupied by the low income groups in which money paid for housing must be made to give shelter to as many persons as possible; this results in overcrowding of dwellings, especially of the Negro population for whom available housing is usually restricted in Maryland. Overcrowding in turn leads to inadequate provisions for sleep, quiet and the preparation of food. I cite one case, a male TB patient left the hospital against advice. He now lives in the kitchen of his son's three room apartment. The other occupants of the apartment are the son's wife and his five children.

When poor housing has inadequate heating, as is often the case, it tends to crowd the whole household into the better heated portions of the house in cold weather, further creating conditions which lower the body's resistance to disease.

This same low income group suffers basic nutritional needs. Even when the breadwinner is employed, there is frequently not enough money to provide adequate food. If the family becomes dependent upon public funds such as our community offers, the situation usually becomes worse.

Clothing is also a neglected item, even though we realize clothing is important for warmth and protection, as well as for keeping up the morale of patients and families. Many families cannot even afford the basic pajamas, robe, socks and slippers required for State Sanitorium admission.

It is in this type of setting that many of our tuberculosis patients wait for months prior to hospitalization. It is often to this type of home, too, that many of our patients return. Even under the most alert supervision of the public health nurse, new cases of tuberculosis are likely

[4] Public Health Nurse.

to continue to occur for these two reasons: the infection had probably taken place but was not apparent before the patient was removed; and/or the same predisposing factors remain.

DR. BARNWELL: Thank you, Mrs. Henson. I know Mrs. Henson must think that the Public Health Nurse has too many jobs now and that we'd never have enough Public Health Nurses, but there is one other function I'd like to see them undertake sometime. I hope when I get around to it that you will give me an opinion of that, and that is in their visit to the homes of patients to do the gastric analysis, do they do the gastric aspiration there, before the patient gets out of bed instead of marching him three hours downtown to some clinic before his stomach is washed out for tubercle bacilli.

Now the next on the program is Dr. Leon Hetherington, Chief of Bureau of Tuberculosis, Maryland State Department of Health. "Hospitalization vs. Home Care in Tuberculosis."

HOSPITALIZATION VS. HOME CARE IN TUBERCULOSIS

LEON H. HETHERINGTON, M.D.[5]

The advantages of hospitalization in treating individuals suffering from pulmonary tuberculosis is apparent to any physician who has had intensive training in a tuberculosis hospital where all of the modern and necessary patient services are available.

In the hospital, the diagnosis, prognosis, complete evaluation and planning for the future usefulness of the patient can be arrived at at the earliest interval of time. Under the constant supervision of medical and nursing personnel, symptoms of a minimal character can be detected at the earlier interval and the appropriate steps taken to combat any increase in activity of the tuberculous lesion. Plans for rehabilitation should begin as soon as the diagnosis and evaluation have been completed. The patient can, slowly and safely, be helped to adjust physically and emotionally to his future life.

In the hospital, the social worker serves the needs of those in need of personal help or of those families in need of help. She may be the first to call the attention of the physician to suppression or an early emotional disturbance and thereby secure early consultation of the mental hygienist if the physician in charge confirms her suspicions.

The basis of treatment in tuberculosis is and always will be physical and mental rest and relaxation. It is also much easier for the newly diagnosed patient to observe prescribed rest and regular hours when others in the hospital are following the same or comparable routines. At home, when the physician prescribes rest to the average individual, the patient's conception usually is that intensive rest means "to sleep in" in the mornings, to stop work but possibly not to forgo all of his usual diversional activities. At home, gradually, even if the actual hours of rest are set down in writing, the tendency of the patient is to drift into irregular habits. This is almost irresistable. The attitude of the patient, after minor infractions and when he notes no adverse sympsoms, is an increase in the irregularity and also an increase in his physical activities. He then begins to doubt the necessity of a strict regime of rest. The result is that recovery in these patients may be delayed or the opportunity to recover may be lost entirely.

Needless to say, anyone with tuberculosis who has a positive sputum is a source of danger to others and from a Public Health standpoint needs hospitalization to lessen the dissemination of his tubercle bacilli to others in the home or among his associates.

For those patients in whom the tuberculosis physician believes home treatment will be sufficient, a short stay in the hospital for the educa-

[5] Chief, Bureau of Tuberculosis, State of Maryland Department of Health.

tion and training of the individual patient would undoubtedly be of considerable benefit. There are occasional patients who do not adjust to hospitalization from an emotional standpoint. These cases must be evaluated by the Mental Hygienist and if he is of the opinion that home care would be more suitable from the emotional standpoint, this recommendation should be accepted if home conditions are suitable; that is, a room alone, no small children, an understanding family or member of the family and sufficient resources for proper food and care. It should, however, be strongly emphasized that these patients are a challenge to the entire staff. Usually there is some problem or problems disturbing this group of individuals and if the social worker, the physician and the nurse can secure the confidence of the disturbed patient so that he will confide in one of them, help may be offered and he may then become a cooperative patient.

All cases in need of thoracic surgery should be hospitalized for proper evaluation, diagnostic workup and preparation prior to surgery and for sufficient postoperative period to insure the best medical results. It is, perhaps, not necessary to emphasize that pulmonary tuberculosis is a disease of medical import and that surgery is performed with the medical aspects in mind.

Eligibility for Admission

Maryland is one of nine states in which the means test has been abolished in so far as cost of hospitalization in the Maryland Tuberculosis Hospital is concerned. Tuberculosis occurs more frequently in those of a lower economic scale and to impose charges on this group would hasten the day when welfare support would be required. Financial worries in the past did cause some patients to refuse hospitalization and worries of any type do tend to retard recovery. Where large families are involved, financial worries are quite often of serious import.

In the last year the charges and the amount of money collected for hospitalization in the Maryland State Tuberculosis Hospitals was, in effect, so small that the cost of investigating financial resources would exceed that amount. All legal residents of Maryland are eligible for hospitalization. In addition, at times non-legal residents must be removed from general hospitals, inns, rooming houses, etc., because of the medical and economical need. We put forth our best effort to return this group to the state in which they have a legal residence for hospitalization. Frequently we are unsuccessful and only a small number of states will cooperate in this transfer. There are, also, some "roamers" who have no legal residence and from a public health standpoint, it is necessary to provide facilities for their isolation.

If an individual moves to Maryland, secures what seems to be permanent employment and then develops active tuberculosis, he may be admitted to a state hospital before his legal residence has been established. In this group we are also usually unsuccessful in having the state from which he came assume the responsibilities of hospitalization.

If a patient suffering from tuberculosis moves into this state with relatives or friends in what seems to be a desire for hospitalization in this area we make every effort to return them to their state of residence if hospitalization becomes necessary.

Custodial Care

There are always a number of "good Chronic" cases of tuberculosis; i.e., open infectious cases who are asymptomatic. It is quite true that more "new cases" of tuberculosis occur from contact with this group than from a similar number of active treatment cases who have symptoms. If this type case has a home with no children or very young adults, a room to himself and economically independent, if he is also intelligent, sanitary and cooperative, we will release this group to their homes as maximum hospital benefit cases.

It is my earnest hope for the future when the number of cases needing hospitalization decreases

to the point where there are vacant beds in our State Tuberculosis Hospital that the pavilion areas, particularly at Mount Wilson and Victor Cullen Hospital, may be used for this type case in which the home surroundings are not suitable for isolation or if the person is a somewhat uncooperative individual. This would undoubtedly tend to lessen the dissemination of tubercle bacilli and thereby reduce the number of new cases. In fact, at the present time, a very small number of our beds in the pavilions are carrying what could be described as custodial cases.

Compulsory Hospitalization

At the present time, patients suffering from tuberculosis cannot be compelled to accept hospitalization in this state. North Carolina has had a tuberculous prison operating for a period of years which appears fairly successful. One far Western State has recently established compulsory hospitalization for the incorrigible type of individual who is a public menace. The operation of this detention tuberculosis hospital has not been in operation for a sufficient period of time to determine the effects upon the public. To describe it briefly, a patient may be confined by court order for a period approximately six months. If, in a shorter period of time than that, he ceases to be a source of danger bacteriologically, the medical staff may recommend his discharge. At the end of approximately six months, if he has to remain in a tuberculosis hospital and if cooperative, he may be returned to the Tuberculosis Sanatorium from which he came or in his own county. If he remains cooperative there, his cure may continue in the county Tuberculosis Hospital. However, if he again becomes an incorrigible type of individual, he may be returned to the detention hospital. The Tuberculosis Control Officer in that state is of the opinion that this hospital has had a psychological effect upon uncooperative patients. It will, of course, take a period of time to determine just how effectual it is.

I do not know if this state will ever have compulsory incarceration of infectious cases who by their actions are considered a source of danger to those in the public with whom they come in contact. We know that quarantine and vaccination has reduced smallpox until it is almost nonexistent today. We also know that, at present, for each death from smallpox in the United States, there are many thousands who die from tuberculosis. We also know that the chronic case and the uncooperative case disseminate infection to a much larger number than the individual who requires active hospital treatment.

At the present time, there is a law in Maryland which makes it possible, by the preferring of charges by the local health officer in cooperation with the State's Attorney and Judge, to confine to their own quarters open cases of tuberculosis who frequent bars, restaurants and other public places and by their actions indicate their carelessness in ordinary personal hygiene. This has been used on rare occasions.

If compulsory incarceration of the incorrigible type of patient should ever be written into the law, I believe it should be used sparingly. Such a law would need to be written as a protection device to the public and not as a law indicating punishment to any tuberculosis patient. This law would need to be administered from a medical or contagion point of view. It is our hopes in the near future to evaluate, over a period of at least one year, the number of patients leaving our hospitals AMA or AWOL and have the superintendent of each hospital indicate his opinion as to whether these are careless, uncooperative, or incorrigible types of individuals. We will also need the information concerning such types of individuals who are not hospitalized but are located in the various counties and cities and are usually known to the Health Departments of those areas. A great deal of thought needs to be given to the advisability and nonadvisability of compulsory incarceration by the medical profession, by the health officers of the

state and by qualified lay members of the public. If such a law is ever proposed, it must contain protection for the individual citizen.

DR. BARNWELL: Does the Maryland Law specifically say "Bars"?

DR. HETHERINGTON: The Maryland Law says: "Public places like frequenting Bars" they can be declared a nuisance and under that confined to their own quarters.

DR. BARNWELL: It is a most interesting problem. I assumed the State Dr. Hetherington was referring to, was the State of California. That State has a particular place, within the State Prison System. The only place available unfortunately is a place named Terminal Island, that is where those patients go. California also has the difficulty which I suppose you have, of not having enough beds, therefore frequently enough the Courts refuse to order a man into a bed knowing there were willing people waiting to get into a bed. The other system which I think is working much better is in the State of Washington where they have enough beds for all patients. There is a locked ward of twelve beds within that thousand-bed institution, and the presence of those six, seven or eight patients in those twelve beds is enough to keep the other sixty patients who are scattered through the hospital and who have been committed, decent citizens.

Now, the next paper is by Judge T. J. S. Waxter, Director, Department of Public Welfare.

IRREGULAR DISCHARGES FROM TUBERCULOSIS HOSPITALS FROM THE POINT OF VIEW OF SOCIAL FACTORS INVOLVED

THOMAS J. S. WAXTER, ESQUIRE[6]

Dr. William Osler once made the very sage remark that tuberculosis was a social disease with medical implications. At least, he was reputed to have stressed the fact that in the terms of active tuberculosis, the social situation, mental attitude and emotional adjustment of the patient were certainly as significant as the actual therapy used by physicians, nurses, etc.

The employee of the assistance division of a welfare department in a large city is certainly well adjusted to the social implications in the treatment of the tuberculosis patient. In Baltimore, there are a good many families being maintained on public assistance because the bread winner is in a tuberculosis hospital. In the not too extreme instance, the man and wife and, let us say, two children are getting along in a reasonable manner, the man earning some $65 a week, when he finds that he has active pulmonary tuberculosis and must go to a hospital. For the man this means that he is a patient in a tuberculosis hospital carrying the heavy and angry mental load of knowing that his family is living on relief standards. To the wife it means that her income is reduced to a third of what it formerly was and she does not have her husband to share in making the decisions that come up day to day in family living. It is impossible for her not to carry some of this to her husband when she visits him in the hospital.

This burden, added to all of the other conflicts, pressures and attitudes that the patient develops about his health and personal difficulties in general while being in a hospital, makes satisfactory treatment extremely difficult and increases the possibility of an irregular discharge enormously.

Ideally, when the wage earner with tuberculosis goes to a sanatorium, ways and means should be devised so that the wife and children on the outside continue to enjoy the same standards of living that they had while the father was working. There is at least one state in the country, Colorado, where, I am advised, a special fund is available for the family whose need grows out of the fact that the father is in a tuberculosis hospital.

This kind of specialized treatment is pretty difficult to justify excluding as it does the needs

[6] Director, Department of Public Welfare.

of widows and families where the head is in a mental hospital, etc.

In a way, it sharpens up for the people interested in tuberculosis an interest in the whole matter of standards of assistance. The money which goes to people in need—financial help from the public.

Certainly, in all cases where the family is receiving public assistance while a member of the family group is in a tuberculosis hospital, there should be the closest working relationship between the assistance giving agency and the hospital, etc., and both should plan together the future adjustment of the patient—always with the patient.

I have only mentioned one instance, perhaps an extreme one, where the social situation bears heavily on the patient and certainly interferes with recovery. There are innumerable variations.

I know of a man now in one of the State hospitals who is vitally concerned about the activity of his wife with other men while he is a patient in the hospital. There is the factor of children getting almost completely out of hand as the patient in the hospital has been the parent who assumed primary responsibility for the children. In other words, there are an endless variety of factors on the outside which affect the patient's attitude in the hospital and which are important in terms of recovery and adjustment.

The patient, even upon his discharge, may not be able to go back to the same type of work that he had before his admission and the whole matter of re-training for a lesser job and at a lesser salary may be involved. The variations that can come up are innumerable but they all point to the fact that a greater degree of cooperation between the people in charge of institutional care and social agencies on the outside should be much closer than at the present time.

DR. BARNWELL: Thank you, Judge Waxter. I think the City of Syracuse has made some attempt towards supporting the family also while the patient is in the hospital, and I think some of our South American neighbors have gone way beyond that and do routinely support the family while the patient is in the hospital. The unfortunate part of their law is, it is limited to curable patients and as soon as it is determined this patient is not getting well, he is thrown back into the family. They have some other advanced ideas. They allow their convicts, down there, to take their wives to prison with them.

The next paper is by Miss Myrtle Dooley: "Nursing vs. Nurses." Miss Myrtle Dooley, Assistant Director of Nurses, Baltimore City Hospitals.

NURSING VS. NURSES

MYRTLE DOOLEY[7]

We have heard a great deal about the shortage of nurses in the past several years. The emphasis is placed on the availability of the Professional Nurse, or as she is often called—the Registered Nurse, who has had three years or more preparation. This shortage has always existed in hospitals or institutions caring for patients with tuberculosis and for three very good reasons. First of all Tuberculosis Nursing has not been part of the basic curriculum in schools for nurses, theory has been scanty, and clinical experience almost entirely absent. Secondly, the nature of the disease and the type of treatment offered the patients has not made the field attractive to nurses. Thirdly, the location of the hospitals is usually far from professional activities and recreational facilities. As the Professional Nurse has extended her interest and increased her years of preparation, it is not reasonable to expect her to select an area of nursing where she will be isolated from her own professional group and from other professional groups who now work closely with

[7] Assistant Director of Nurses in charge of Tuberculosis Service, City Hospitals.

her. I do not feel that I need to develop these three statements other than to point out that the second, namely the treatment of tuberculosis is undergoing a change. It has been accelerated greatly within the past three years in comparison with the past fifty. However, the recognition of the value of bed rest is still strong within us and the nurse is the key person in the phase of treatment. With the nursing shortage growing more acute, leaders of the profession are coming to the conclusion that the only practical way to get more nursing service lies in using the present nurse supply more efficiently. Almost everybody has found the same practical answer; they hire more practical nurses, attendants, and nurses aides and use them under the supervision of the professional nurse. They work closely with other professional groups in the total care of the patient.

We at City Hospitals, Tuberculosis Service, have been working on a program of this kind for the past few years. So far we have been able to take care of patients in bed as long as the doctor feels it is necessary. We have a doctor who heads a team or a group of professional people who are involved in the overall planning and execution of the care of patients with tuberculosis. There is a medical social worker, vocational counselor, occupational therapist, a rehabilitation director, a chaplain, and two nurses. We work closely together. Every Tuesday morning we have a conference. We discuss our mutual problems and responsibilities. The doctor guides us in our work with the patient, outlines briefly the plan of treatment, and starts the plans for discharge. Each member of the team feels free to ask questions and find out just where his responsibilities lie. The nurse and doctor have more contact than any other members of the team. She attends all of the medical clinics where the discussion of medical plans take place. Attendance at the clinics gives her information about her patients with a minimum use of the doctor's time. The nurse must understand these plans for a large part of her work is teaching her patient how to do things for himself, getting him to accept care from others when he does not feel ill, and helping to understand medical recommendations. She is the only member of the staff who sees the patient's family and other visitors and can keep the other members of the team informed about social problems that arise. If she is alert and interested, she utilizes her opportunities in the overall tuberculosis control program by working with the patient's families to have them X-rayed and seek medical advice. Often these activities take more of the nurse's time than doing the routine tasks commonly thought to be her responsibility.

As a member of the second team, the nurse is a teacher and supervisor. She is the head of this team. She plans the bedside nursing care of the patients and teaches the new personnel the routines and procedures. For a number of years at City Hospital we have employed Licensed Practical Nurses for the activities at the patient's bedside. They are nurses who have had one year's training and have been licensed under the Maryland State Board of Examiners of Nurses. They are prepared to give all medicines, carry out treatments, and take care of supplies. The morning following the medical clinic where treatment of patients has been planned, the nurse who attended the clinic discusses these plans with the nurses on the division where the patient is located. She gives them this information in a form they understand and can find their place in it. Insofar as it is possible and helpful, we give these nurses the result of the Tuesday Morning Staff Conference. We not only hold these smaller conferences but once each week all the Licensed Practical Nurses meet to discuss the problems that arise within the department of which they are so vital a part. The next group of workers in this team are the hospital workers. They are made up of men and women who are trained on the job. This is the weakest part of the team, not because we do not recognize the value of their contribution but because so little work has been done to stabilize

their jobs, both from the training and the economic aspects. We hope that in the not distant future that housekeeping and diet kitchens will be removed from the nursing service, that ward clerks will be added to the team, and that even a ward manager may be installed as has been the case in some of the more progressive hospitals.

These activities and people mentioned represent our efforts to solve some of our nursing problems in a city hospital tuberculosis service. They leave much to be desired. We feel we have made progress by discussing *Nursing* rather than *Nurses*.

DR. BARNWELL: You know certain hospitals get certain reputations and they are not always exactly what you expect. The thing I have heard most about the Tuberculosis Service in this large City Hospital here is the sacred inviolability of the rest hour. You can imagine the relief and the delight with which I met such a gentle person who has accomplished such a reputation.

The next paper is by Dr. G. Canby Robinson, Director of the Maryland Tuberculosis Association. "Social Service and Rehabilitation in the Treatment of Tuberculosis."

SOCIAL SERVICE AND REHABILITATION IN THE TREATMENT OF TUBERCULOSIS

G. CANBY ROBINSON, M.D.[8]

The successful treatment of tuberculosis is at best a long, slow process, from the time a positive diagnosis is made until the patient is able to resume a normal, independent place in society. Throughout the tedious months or years of medical care, the cooperation of the patient is an essential factor in successful treatment and in order to encourage and foster the spirit of cooperation, patients from first to last must be given careful consideration as individuals. They must be given an understanding of the situation they have to face and must feel that their personal problems are understood and are being given consideration.

The diagnosis of pulmonary tuberculosis almost invariably brings to the patient a variety of social, economic and emotional disturbances which add greatly to the burden of the disease, and which need careful individual consideration in order to minimize their harmful effects on the course of the patient's illness. It is frequently the patience and skill with which these disturbances are studied and treated throughout the various phases of the illness that determine the ultimate outcome of the long battle tuberculosis imposes upon patients and physicians.

[8] Executive Director of the Maryland Tuberculosis Association.

It is the purpose of this paper to discuss briefly the plans and provisions for the study and treatment of the personal problems of patients in the public tuberculosis hospitals of Maryland, and to point out the value of what may be called the extra-clinical services in the control of tuberculosis.

The medical social worker has an important part to play throughout the course of the illness. Her service is of much value in preparing the patient to enter a hospital, in helping to meet the problems that make it so difficult to carry out the long period of hospital treatment and in preparing favorable conditions for discharge.

Her study of the patients' social and personality problems, after they are first informed by their physician that they have tuberculosis, is often of much importance in revealing their reaction to the disease and in preparing them for the hospital care their disease demands.

The social worker can do much at the beginning to establish a spirit of cooperation by helping patients to understand the need of treatment and isolation, and by solving some of the problems that may seem insurmountable barriers to their acceptance of the regime they are expected to follow.

Although the social worker can render a valu-

able service in the chest clinic, where the diagnosis is made in a large proportion of patients receiving public care for tuberculosis, only one such clinic conducted by the Baltimore City Health Department, the clinic of the Druid Health Center, has a medical social worker on its staff, where the social worker is supported by the Maryland Tuberculosis Association.

In the tuberculosis hospitals operated by the State Department of Health encouraging progress has been made in the development of social and rehabilitation services. The State Bureau of Tuberculosis has an experienced medical social consultant on its staff who has had special training in tuberculosis and is responsible for the social service in the Victor Cullen, Mt. Wilson, Henryton and Pine Bluff Hospitals. A professional social worker has been secured for Henryton, the hospital for Negro patients, and two social workers have been assigned to the Mt. Wilson Hospital by the Whear Ridge Foundation. A new worker is to join the staff at the Victor Cullen Hospital in July.

Social workers interview the patients soon after their admission, study their emotions and personality, discover their social and economic problems and endeavor to clear up the circumstances that may interfere with their ability to relax and rest in mind as well as in body. Patients need help in adjusting to the new surroundings and routine of the hospital, in order to get the full benefit of its service, and the social workers take a leading part in this process.

The extra-clinical services are conducted by a team of professional workers, consisting of occupational therapists, librarians and vocational rehabilitation counsellors, who coordinate their activities with those of the social workers.

At the Victor Cullen Hospital an occupational therapist and his assistant conduct work shops for men and women, teaching handicrafts, typewriting, dressmaking and home management to ambulatory patients. Other forms of constructive work are provided for bed patients. Similar activities, on a more restricted scale, are carried on at Henryton. At Mt. Wilson a part-time occupational therapist, supported jointly by the Baltimore Tuberculosis Aid Society and the Maryland Tuberculosis Association, has developed a successful service which has given bed patients opportunities to carry on stimulating and diversional art and craft work, to which the patients and the staff have responded with interest and appreciation.

Patient libraries, conducted by full-time professional librarians, have been organized in the Victor Cullen and Henryton Hospitals through the cooperation of the Maryland Tuberculosis Association and the Library Extension Division of the State Department of Education. These librarians spend a large part of their time with the patients, not only supplying them with suitable reading material, but also encouraging and guiding their reading in preparation for future occupations and in developing new interests of lasting value.

Vocational rehabilitation is made available to tuberculosis patients by the Rehabilitation Service of the State Department of Education. The State hospitals are covered by a Counselor, well trained in the field of tuberculosis, who has done much in developing the work shops and occupational opportunities in the hospitals.

Whenever the patients show sufficient progress toward the completion of their hospital care, their occupational possibilities are studied and a plan is made in relation to their medical prognosis and potential physical ability. Their aptitudes, desires, social status and past occupational history are given careful consideration, and when indicated, training in fields of work best suited to their individual needs is arranged by the Rehabilitation Service. This training, provided by State and Federal funds, usually leads to successful employment, which is supervised by the Service.

During the year ending July 1, 1951, 126 tuberculosis patients were trained and placed in suitable employments, by which they were made self-supporting. The cost of this training

was $36,000.00, while the salaries and wages they were receiving on July 1, 1951, aggregated $142,000.00 a year. These figures indicate the economic value of this Service, as undoubtedly without it, many of these patients would continue to be public charges, to be supported by their families or to be living on resources they had not earned.

Social workers, occupational therapists, librarians and rehabilitation counsellors work together as a team, and participate in planning the medical care of patients. They take part in the clinical conferences in the hospitals and their services are thoroughly accepted and intelligently used by the medical and nursing staffs.

It has been interesting to watch the definite changes and improvements in the care of patients that have recently taken place in the State tuberculosis hospitals. The development of social service and rehabilitation has been an important factor in these improvements, and have undoubtedly helped to lessen the number of patients leaving the hospitals against medical advice, by creating a better understanding and cooperation between patients, doctors and nurses which adds greatly to the efficiency of treatment.

The same developments of the extra-clinical services are going forward in the Tuberculosis Division of the Baltimore City Hospitals, where there has been a striking decline in the number of patients leaving against medical advice, which is concrete evidence of progress. These services will be more fully developed when the new 300-bed addition is opened there, and a similar expansion will undoubtedly occur with the opening of the splendid new building at Mt. Wilson within a few months.

The present situation in regard to the social and rehabilitation services in all of the public tuberculosis hospitals in Maryland is promising, but only a beginning has been made. The present personnel is much too small in numbers to meet many of the social needs of patients, but a demonstration is being made of how these needs should be met, and the value of these services in the medical care of tuberculosis.

The Maryland Tuberculosis Association is much interested in these services to patients, and has for several years expended a considerable portion of its Christmas Seal Sale funds for their development. The Association has endeavored to exert leadership in this field, as it is convinced that they have a valuable contribution to make, not only to the care of individual patients, but are an important element in the program for the control of tuberculosis.

DR. BARNWELL: I always found Dr. Robinson helpful to the Veterans Administration in establishing a 300 bed hospital in this city. I hope he, the members of this panel and the members of this audience will help us in integrating that hospital into the facilities of this community as a hospital for diagnosis, treatment, teaching and research and prevention. We may seem to have some advantages in a hospital of that sort, particularly in physical facilities, and I'd like you to know one handicap that the Veterans Administration feels it had and that is that while we try to integrate ourselves into the community's facilities, we must realize that we are dealing with the control of Tuberculosis within a segment of the population. We stand to lose in the same way that industry lost when it attempted to control Tuberculosis in miners, that is, the men who actually went into the mines, and soon found that unless they or somebody else controlled Tuberculosis in the home, no one could control Tuberculosis in a given segment of the population.

The next paper is by Dr. Philip Sartwell, Associate Professor of Epidemiology, School of Hygiene, Johns Hopkins. "The Effect of Improved Therapy on the Sanatorium Bed Situation."

THE EFFECT OF IMPROVED THERAPY ON THE SANATORIUM BED SITUATION

PHILIP E. SARTWELL, M.D.[9]

Most physicians will agree that premature sensational claims for a new treatment, especially in such diseases as tuberculosis or cancer, are unwise and may even do serious harm. The recent claims in the lay press for the newly developed drugs, isonicotinic acid hydrazide and its analogues, were of this sort. One of the chief dangers, is that agencies responsible for tuberculosis control may decide to reduce their appropriations and activities, such as the provision of sanatorium beds.

Now the truth of the matter is that if the new drugs are similar to streptomycin in their action but more effective, sanatorium bed requirements are not likely to be diminished but may actually increase. This statement is predicated on the assumption that it will still be advisable to treat pulmonary tuberculosis in a sanatorium. The basis for this belief can be seen if we examine the rates of discharge and death at a sanatorium and observe the effect of changes in these rates.

Dr. Frank Weber has recently made a study of irregular discharges from a Maryland sanatorium for Negroes, covering a three-year period from January 1, 1948, to December 31, 1950. The probabilities that patients admitted in the first two years of that period would die in the sanatorium or be discharged either with or without medical approval have been calculated for each time period after admission. At this particular institution, it is to be expected, based on this experience, that at the end of two years following their first admission, 51 per cent of patients will have died, 20 per cent have been discharged without medical approval and 13 per cent discharged with consent of the staff. The median duration of stay was 6½ months.

Now let us suppose that the efficacy of the new drugs will be such that the risk of mortality among patients in sanatoria in all stages of treatment is reduced exactly one-half by the new treatment. We will further assume that the likelihood of a patient being discharged with a successful outcome, that is, of being discharged with medical approval, is doubled and that the frequency with which patients leave the institution against medical advice is unaffected. Let us apply these altered probabilities to the experience of this sanatorium. We find that by cutting the sanatorium mortality in half and doubling the probability of medically approved discharge, the median length of stay of patients from the time of their first admission would not be diminished but increased from six and a half months to over eight months. The earlier experience was that 16 per cent of patients were still in the institution two years after admission; under the new conditions this proportion would actually be increased to 21 per cent. The reason for this, of course, is that our therapy will have prolonged the lives of many patients admitted in an advanced stage, who constitute a large proportion of admissions, and of patients with disseminated forms of tuberculosis, who in an earlier period would have succumbed rapidly after admission. In other words, a subacute disease is converted into a chronic one. I am told by clinicians that this has been the observed effect of streptomycin therapy and that as a result sanatorium waiting lists are now longer than previously. It may be expected that the new drugs, if effective, will accentuate this trend rather than diminish it and that the need for sanatorium beds in this area will continue to exceed their number for years to come unless, of course, our therapy leads to almost immediate cure of the disease, which is most improbable. In addition it may be expected that the number of patients needing thoracic surgery will increase.

[9] Associate Professor of Epidemiology, Johns Hopkins School of Hygiene.

Ultimately the declining morbidity from tuberculosis can be expected, if present trends continue, to bring down the requirement for beds. To await that day complacently, however, would be most unwise. In the past no strictly therapeutic measure has alone been shown to be capable of controlling the incidence of a communicable disease. Protection of the public against dissemination of tuberculous infection is a highly important function of the sanatorium, as important as it has ever been in the past.

DR. BARNWELL: The next paper is that of Mr. Harvey Weiss, Superintendent, Sinai Hospital. "The Role of the General Hospital in Tuberculosis."

THE ROLE OF THE GENERAL HOSPITAL IN TUBERCULOSIS

HARVEY WEISS[10]

The fact that tuberculosis is one of the oldest known diseases and the fact that it is so widespread is certainly not news, at least to a group of this type. These facts are only restated to remind ourselves that during these long years our concepts in the treatment and management of tuberculosis have changed many times.

While today the medical treatment of tuberculosis is primarily considered the function of the special hospital, the general hospital is beginning to play a more important part in the over-all problems of its management. This development is a natural one, when we consider general trends in medical care. We are still operating in the throes of specialization in all branches of medicine, but more and more the pendulum is swinging towards generalization. True, it is slow, and where it will stop cannot be too accurately predicted, but we do know medical centers where specialization and generalization can be practiced together are being rapidly developed in various parts of the country. More and more our thinking is beginning to crystallize on various factors which favor bringing the tuberculous patient closer to, if not into the general hospital.

The factors which are making us think of this relationship are many, and all of them need to be studied and weighed before coming to a definite decision. At the same time, these factors cannot be ignored in the efforts of a community to solve its problem in relation to tuberculosis. Briefly, some of these factors may be stated:

1. The general hospital is the greatest depository for acute illness.

2. As such, it is the place where the diagnosis is made.

3. In order to make the diagnosis, it must provide the special ancillary facilities such as clinical laboratories, X-Ray laboratories, trained medical, technical and professional personnel needed to achieve this purpose.

4. The general hospital is the training center for all types of professional personnel such as medical, nursing and other groups.

5. It is the largest reservoir for the diagnosis of cases of special diseases such as tuberculosis.

6. It is best fitted to manage the surgical treatment of tuberculosis.

7. The general hospital is usually located in the larger population areas where all types of personnel are more readily available.

There are other factors. I have cited enough to point out that the general hospital must, because of its modern functions, play an important part in the care and treatment of tuberculosis.

If we accept the medical center plan which embraces a physical union of the tuberculosis hospital and the general hospital, we are talking about the ideal situation as we see it today. However, for the present, this ideal arrangement will only prevail in most instances in commun-

[10] Superintendent, Sinai Hospital, Baltimore, Maryland.

ities which already have them, or where new hospital planning and construction are taking place. In the application of the Hill-Burton Act for financial aid to states for hospital construction, tuberculosis divisions in general hospitals are given top priority. As a result, many installations of this type are being built. Until this program is more fully developed, the general hospital can ill afford to shut its eyes to cases of tuberculosis.

There will always be cases of tuberculosis in a general hospital, even though some of them are not diagnosed. The general hospital should recognize this fact and become a member of the team by adopting well established procedures so necessary in the over-all program in controlling tuberculosis:

1. Pre-admission chest x-rays for in-patients.
2. The same chest x-rays for out-patients.
3. Chest clinics which are teaching clinics.
4. Follow-up clinics.
5. Teaching of isolation techniques to Medical House Staff, Nurses, Dietitians, etc.
6. Establishment of Medical Social Service Departments.

All of this can be done without being physically connected to a special hospital.

This is one of the ways the general hospital can prepare itself for the time when tuberculosis divisions will become integrated parts of general hospitals, if this be the accepted practice.

DR. BARNWELL: I will be interested to see what that priority in the Hill-Burton Act will do. We have a priority in the Veterans Administration also but priorities do not overcome prejudices.

The next paper is by Dr. Vernon Langeluttig, Assistant Professor of Medicine, University of Maryland, Medical School. "Teaching of Tuberculosis in the Medical School."

THE TEACHING OF TUBERCULOSIS IN THE MEDICAL SCHOOL

H. VERNON LANGELUTTIG, M.D.[11]

The subject of this presentation has been studied by various groups over a considerable period of time. The latest study of this kind was that of the "Council on Undergraduate Medical Education"—a committee of the American College of Chest Physicians. The report of this committee appears in the March issue (1952) of Diseases of the Chest. There is very little that I can add to their findings, however, there are certain impressions which I have gained in my experience, both as a teacher of diseases of the chest and as a clinician.

It is generally agreed that the teaching of tuberculosis and diseases of the chest have been lackadaisical in many respects. The Council, in an endeavour to determine the methods and amount of teaching done in tuberculosis, sent questionnaires to all medical schools in the United States and Canada. From the replies received the following pertinent facts were discovered:

1. In some institutions there was a dearth of teaching material because of the absence of tuberculosis sanatoria, or there was poor co-operation between existing sanatoria and the medical schools.

2. In some schools students are given assignments in textbooks of general medicine and physical diagnosis. The implication here, of course, is that such texts are usually very much out of date and thus grossly inadequate to a proper knowledge of the subject.

3. Many teaching hospitals are completely adverse to admitting tuberculosis patients and thus neither medical or nursing students have any contact with the disease.

[11] Assistant Professor of Medicine, University of Maryland Medical School.

4. In a few schools the teaching of tuberculosis is frowned upon for reasons considered legitimate because of prevailing conditions.

5. In some instances the subject is taught as part of the general medical course, and, by volunteer lecturers. (This latter point is given much stress.)

In my opinion there are a number of reasons for the neglect of this most important phase of our medical educational program:

1. There exists a general feeling that, since tuberculosis is a disease usually treated in city and state institutions, there is little for the practitioner to do except refer suspected cases to the sanatorium or local tuberculosis clinics.

2. The feeling exists; and I personally have heard it expressed by competent authority, that the disease itself takes such a high toll of students, internes, and nurses, that practical work in tuberculosis wards should be abolished, and all contact by students be avoided.

3. The fact, that in general, the subject of tuberculosis has been taught for a long time as a part of the general medical lectures, and usually by one who is not a specialist in this field but a general medical man.

As regards item #1, it is a certain fact that much valuable time is wasted in already overcrowded sanatoria by the lack of knowledge of the disease and its differential diagnosis. Too many non-tuberculous cases are mistakingly sent to the sanatorium when they really belong in the acute hospital. The graduating student should by all means have a good working knowledge of the simple diagnostic procedures, such as sputum and gastric examinations, tuberculin tests, and also the value of the more technical and skilled procedures, such as bronchoscopy. Inasmuch as there are upwards of seventy pulmonary conditions which must be differentiated from tuberculosis, the study of all diseases of the chest must be emphasized to a greater degree, and as our knowledge increases and our temerity in exploring the chest surgically is lessened, this greater emphasis becomes more and more important. Also, without some understanding of pulmonary function and function tests the pitfalls of modern therapy may well be overwhelming. Students must have some basic knowledge of these facts and they must be incorporated in the curriculum.

With respect of item #2, the argument that teaching along practical lines, requiring work in the tuberculosis ward, is fraught with so much danger to the medical student and the nurse, would if followed to the letter, leave us without anyone to take care of the tuberculous. This type of specious argument has already made itself felt to the detriment of our sanatoria and hospitals. Most phthisiologists are well aware of the difficulty in obtaining internes and nurses because of the fear of contracting the disease. In my own experience most of the internes and nurses who have contracted tuberculosis have done so from contacts in the general hospital, in the accident room, in pathology, and on the general wards, especially surgical. Proper teaching and indoctrination should overcome this danger since these professional people should know how to protect themselves. We do not prohibit visitors in our tuberculosis wards.

The third item needs very little explanation. The broad field now covered by diseases of the chest makes it almost mandatory that the subject be treated as a specialty in itself, and since tuberculosis is the principal condition encountered which must be differentiated it must be included in the broad field and its various manifestations understood. As has been mentioned before, surgery of the chest has opened up the broad field of pulmonary function studies and therefore something new has been added which will require further investigation. All this cannot be done in the old slipshod manner if progress is to be made.

There is not time enough here to give in outline what subjects must be covered in order to meet the requirements of a comprehensive study of diseases of the chest, but such an outline is available to anyone interested. The report of

the Council has taken this step and further has published a manuscript on "Teaching Diseases of the Chest in Medical Schools"—Journal of the Association of American Medical Schools, May 1951.

DR. BARNWELL: Thank you, Dr. Langeluttig, I hope that report which you report is not based on a questionnaire. I mistrust questionnaires anyway, and one on this subject addressed to the Deans of Medical Schools I particularly distrust.

The next speaker is Dr. Elmer P. Sauer, Medical Director of the State Tuberculosis Hospitals. I have the same difficulty in introducing Dr. Elmer P. Sauer as I did Dr. Hetherington. I suppose you know the State of Maryland stole them both from the Veterans Administration. "Tuberculosis Treatment: Past, Present and Future."

TUBERCULOSIS TREATMENT: PAST, PRESENT AND FUTURE

ELMER P. SAUER, M.D.[12]

To summarize briefly one might say that in the past the treatment was not too good, today it is fair and in the future we hope it will be good.

PAST

In the past, the dominant theme was that tuberculosis could not be successfully treated. Trudeau caused a significant advance when he advocated the use of rest rather than strenuous outdoor exercise. During rest, it is possible for the body to best utilize its defenses against infection. Sunshine, in large doses was proven harmful. Freezing cold in the past was considered necessary. I can see no virtue in being frozen and I can speak from personal experience. I always felt that only the strong and hardy could survive a northern winter in a sanatorium. Cold always was a good preservative for the tubercle bacillus but not for the human tissues. In the past, distance seemed necessary for treatment. As a general practitioner, I often wondered if the far-away program was not suggested because the doctor felt that treatment was hopeless and the further away the patient was, the better. Altitude, as expressed in mountain heights, has no virtue as such. The stethoscope was extensively used for diagnosis. Early diagnosis was almost impossible due to difficulty in interpretation of findings and the fact the signs usually appear late in tuberculosis.

PRESENT

The foundation for present treatment still lies in rest and good food. We feel this can best be given in the hospital. We feel that here the tuberculous cases can be concentrated and that care can be specialized. The tuberculosis hospital of today, using both surgery and medicine, is very similar to any general hospital. It is essentially a chronic infectious disease hospital. There is no social stigma in the hospital, that some people feel when at home in the Community. The active case is taken from the home to break the possibility of further spread. Much can be learned about the proper care for tuberculosis. Each patient has a common problem. The hospitals are often built near home so that visiting can be made easier. A person in bed for a long time, away from family, is prone to walk out before treatment is adequate unless he has visitors.

Today, mortality is less but morbidity remains high. In other words, we today are finding many new cases but fewer are dying than in the past. In 1900 where eight would die, today only one would die. The declining death rate is not due to medical advance only. Better housing with less crowding, better food, better case-finding and

[12] Medical Director, Maryland Tuberculosis Hospitals.

better education, as well as better medical treatment, are all factors. Very little of bovine tuberculosis is seen today because of pasteurization and tuberculin-testing of cattle. Young people especially women, and older men, constitute the largest part of the case load. Today, we feel that tuberculous cases can get well; especially if seen early. The use of X-ray for screening purposes enables us to find the disease earlier than with the stethoscope.

In the hospital, the treatment is by a team of which the logical leader is the doctor. He must direct the plan of action and vary it as needed. The patient is separated from the community until it is safe to return. Direct sputum examination in the past was considered accurate enough for dismissal of the patient home but today the much more sensitive culture has replaced the guinea pig. It is less cumbersome and much cheaper. General medication is frequently given. Examples are as follows: Cough is lessened by the use of Codeine or one of its substitutes. Hemorrhage usually quiets if cough is lessened and the patient is inactive.

Of the recent drugs effective in treatment, Streptomycin (an antibiotic) is most effective; especially when combined with PAS (para-amino-salicylic acid). If Streptomycin is given intramuscularly two or three times a week, there is little toxicity. PAS is given orally about 10 to 12 grams a day in divided doses. The two drugs used as a unit are much more effective than either alone. Treatment can often be continued for long periods. Occasionally, these drugs have been used for a year or even more. This treatment is useful for both pulmonary and extra-pulmonary tuberculosis. While on this treatment, it is frequently difficult to find a positive culture but when the treatment is stopped, the organisms may grow again. Tibione, one of the drugs of the sulfa series, has found a very limited usefulness. The drug is only slightly effective and very toxic.

Before speaking of any of the newest drugs, may I comment briefly. To really get the latest news on new drugs, watch your daily newspaper. We, in the hospital, are accustomed to start ward-rounds only to be beseiged by patients who want the new drug mentioned in the morning or evening paper. Lately, the newspapers are announcing first and the medical periodicals following. Much of this publicity seems unfair to the patient and doctor, unless one believes variety is the spice of life.

Isonicotinic-acid-hydrazide, a relative of Tibione, appears to be the latest of these new drugs announced. We are using it on a very limited scale and cannot yet say where it will fit into the treatment pattern. It can be given orally and should not be too costly. A drug of this type is needed.

Mechanical rest for the lungs has been used for a long time. Before any treatment is started, a long-range program is laid out whereby many procedures will be used so that the patient will get well as quickly as possible. Rest, collapse and drugs frequently prepare the formerly hopeless case so that excisional surgery can finally be employed.

A brief summary of collapse procedures might be as follows:

1. Pneumothorax is little used now. Probably not over a dozen cases were started in all Maryland State tuberculosis hospitals last year. Too few cases were eventually successful and the complications were too many.

2. Pneumoperitoneum: This has largely replaced pneumothorax as it is safer and easier to use.

3. Phrenics are seldom used as we feel the possibility of loss of useful lung tissue is too great a hazard.

4. Thoracoplasty is a good collapse procedure but the patients often object to the pain and mutilation if the procedure is extensive.

5. Extra-pleural prosthesis may be used; depending on the operator.

Excision. There has been a marked swing in this direction in the past few years. Large caseous masses into which antibiotics have difficulty penetrating can be removed. Cavities, bronchi-

ectatic areas and stenotic bronchial lesions can be removed. Often, after the resection, it is necessary to fill the lung space and prevent overdistension of the remaining lung. Here, tailored small thoracoplasties are frequently used. Let it be emphasized that not all the diseased tissue can be removed. Whether it be thoracoplasty or resection, a long period of bedrest, with or without antibiotics, is needed before the lesion can be brought under complete control. Unless the patient can be returned to the Community as a useful citizen, we do not feel a good result has been obtained.

Initially, the patient is started on bedrest and this is modified as he is physically able to be more active. Many patients are worried. The Social Worker can frequently help with the problems in the hospital or at home and, thereby, relieve some of the worry. Radios, television and movies help pass the months or years. In the latter part of the program, the patient's activity is gradually increased. This is to test the stability of the chest lesion and to ready him for the time of discharge. Here, it is possible to add occupational therapy and *especially* rehabilitation. Many of these people come from the heavy manual-laboring classes and if it were possible for the patient to do more suitable work, there would be less likelihood of a break-down. To teach the housewife easier ways to do housework and ways to prepare better food is rehabilitation and is important. After discharge, the private doctor or clinic takes over the care of the patient.

Future

As for the future: Today, it is possible to look at the past and see its mistakes and, in the future, it will be possible to look back and smile at today's errors. Until we have more knowledge, we must do the best we can with what we have. Frankly, today we do not have a completely satisfactory treatment for tuberculosis. A treatment that will give quick results, easily and surely, without too great a cost is what we dream about. When good medicine is found, the use of collapse therapy and surgery should decline. In the final analysis, I feel tuberculosis will be a disease with medical treatment. Our new 300-bed hospital is being built with the idea in mind that if the Utopia of treatment is found, the new structure can be easily converted to other use. A good case-finding program will always be needed until the incidence of tuberculosis becomes negligible. If this occurs, then it will be necessary that our neighboring nations achieve a like goal if we are to remain free from the disease. It is even possible to dream of a race of people who will have no resistance because they have not been exposed to tuberculosis for many thousands of years. This happened to the South Sea Islanders and, when tuberculosis was introduced, a very acute violent and fatal disease resulted. The present problems are too pressing, however, to dream so far into the future. What we need now is a cheap, orally-effective bacteriocidal drug.

Dr. Barnwell: Thank you, Dr. Sauer. You have heard eleven papers, they are only six minutes overtime, that overtime is due entirely to the moderator venting his prejudices. I'd like now to call for questions to the panel. May I call upon the members of the panel to read the questions which were previously sent in and have them give us their answers. First I'll call on Dr. Silverman.

(Continued on next page)

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QUESTION AND ANSWER PERIOD

DR. CHARLOTTE SILVERMAN: The first question is this:

QUESTION: Do you think the time is right for a city-wide X-ray survey as has been done in Washington, Los Angeles and Boston (and I might add about a dozen other cities)?

ANSWER: I have mixed feelings about this. If we were to do this in Baltimore, it would mean trying to get a major portion of our population over the age of fifteen. It would come to perhaps four or five hundred thousand people, about the number that were done in Washington a few years ago, and we would attempt to do this within a period of several months. We would probably find about eight or ten times the number of cases in that period of time that we find in a whole year now. I don't think that the hospitals could conveniently take them in quickly, but of course it is important to find cases and institute treatment at home. This is an expensive venture and I just throw out the idea that the amount of money involved—Washington estimated it cost them about $250,000—might perhaps be spent in other aspects of Tuberculosis control that are of a more dynamic and continuous nature. I personally favor much wider and closer investigation of associates in Tuberculosis cases and a much greater expansion of a vaccination program.

QUESTION: What are the active figures of the Tuberculosis waiting list at present?

ANSWER: We have about two hundred residents in the City of Baltimore waiting to go into the hospital. This compares very favorably with the situation as of the first of the year when we had about three hundred. But a great many have been taken into the State hospitals and the new wing at Henryton has relieved the situation a great deal.

QUESTION: (This was asked with tongue in cheek, I would think, or else simply to press me to a dreadful answer.) What is the longest time an active case has had to wait or is now waiting Sanatorium admission?

ANSWER: A year ago one of our nurses sent me a private special delivery note saying "happy anniversary" for a particular patient who had just that day celebrated his first anniversary on his Sanatorium waiting list. Our longest experience has been about fourteen months and that has been quite long. A year has not been unusual, and nine months is very common, and a number of our patients now are getting in who were put on lists last July and August.

DR. BARNWELL: It is a common thing in some areas. The Veterans Administration has had as many as five deaths on the waiting list within a period of six months. Now, I'll call on Dr. Racusin.

DR. RACUSIN: The question that has been asked is, "How do you handle the positive sputum patient who has a long waiting period before being admitted to a Sanatorium?

ANSWER: Well, frankly, that is rather a headache, medically speaking. We try to keep the people at rest in bed. We enlist the aid of the public health nurse to come in and supply the individual with material such as sputum cups, etc., etc., also to enlist their aid to try to teach the family how to observe isolation precautions as best they can. But from what has been brought out previously by other speakers, the patient who left on his own is notoriously lax with regard to keeping up the instruction that he has received. Also the morale of that individual suffers noticeably because in the first place, after having been assured that prompt hospitalization is important and having gone to lengths to be honest with him and to tell him what the outlook is in the disease, he then throws at you in your face the advice that you gave him several months previously: "If all this is so important why the heck do I have to wait so long?" This, of

course, results usually in a certain amount of loss of face by the physician in attendance, who in turn takes it out on the authorities by plaguing and pestering. . . . I see Dr. Hetherington laughing, I've worked on him many, many times in the past, plaguing and pestering the City and State authorities to try to get beds for these individuals. Many times, particularly when it is a breadwinner in the family who needs the bed, we have all the other sociological implications, such as the family having to go on relief. It is rather a dismal problem at the present time. Of course we all hope once we have more Sanatorium beds the situation will be corrected, but briefly, that is the way we have been handling it.

DR. BARNWELL: Now we will hear from Mrs. Anita Henson.

MRS. HENSON: My question is: Do all Public Health Nurses spend some time in a Tuberculosis Sanatorium?

ANSWER: Assuming that means as a worker, the answer is "no"; not at this time. However, the Public Health Nurses do attend the team conferences that were mentioned by Miss Dooley, the conferences that are held in the hospital in regards to the care and the probable discharge of the patients. The Public Health Nurses do occasionally make personal visits to the patients and have conferences as often as necessary with members of the staff. I might add that in some areas the need has been seen to include a Public Health Liaison Nurse as a part of the hospital staff, and there is a possibility that trend will extend to this area in the not too distant future.

DR. BARNWELL: Mrs. Henson, would you answer my personal question for my personal information?

MRS. HENSON: About the Public Health Nurse making provisions to have a gastric at home? Well, so many new procedures have been added to the Public Health Nurses' routine that I suppose that would be added before long. The nurse could assume that responsibility if it were planned accordingly.

DR. BARNWELL: Now Dr. Hetherington, your question?

DR. HETHERINGTON: Am I allowed to comment on some of these others before I answer my question? Well, I think in all due respect to those present, we should clarify and explain this waiting list a little bit as it exists at the present time; yesterday I counted the waiting list of the State Tuberculosis Hospitals and I presume that most of those cases on the City waiting lists are also on the State waiting list. Those lists of course are kept separately. As of yesterday there were two white females on the waiting list, one of those is a patient out in Denver, Colorado, too ill to be transported back to Maryland; and the other one came on the waiting list yesterday, so we are very close up on the existing white female waiting list. For the colored female waiting list since we've been able to open a new wing at Henryton, and reopen the floor which had to be closed down due to construction above that floor, there are presently thirteen colored females on the waiting list, which means less than a month old. We had as of yesterday forty-three (43) vacancies at Henryton, about thirty-some of those being colored females which would mean that we are going to have vacant beds at Henryton for a period of time in the female class. With this in mind we have been in conference with the City officials during the past two or three weeks to see what arrangements if any can be worked out to equalize the female and the male colored waiting list since there are approximately one hundred and five on the colored male waiting list. As of yesterday there were eighty-five (85) white males on the waiting list. Now that is much better than we were several months ago, and to bring you up to date, we are admitting presently from the January class, I might say, in the white male waiting list. The colored male waiting list, due to the close-down at Henryton, due to the close-down at City Hospital for new construction, shifting around, etc., we

are admitting late September or early October class and we do hope there can be some equalization so that there will be considerable slack taken up. I can say the waiting list is much shorter now than it has been for many, many months. The morbidity continues. The mortality rate in Maryland in 1945 was sixty. The provisional mortality rate for last year is 29.7, so that we are going to catch up some of these days. We cannot go on building beds, beds, beds, until we are able to staff them and there has to come at some time an equalization point. Now, my first question:

Reverting for just a moment to the question on Nurses, this is my own personal sentiment. I do wish every Public Health Nurse had a period of time in a Tuberculosis Hospital. You can go to the hospital for your conferences which is somewhat similar to tea—I'm not accusing you of drinking tea, but in comparison to the experience that you gain, it is something that is absolutely worthwhile and would be of benefit to all of us. Now, my question.

QUESTION: Do you recommend drug therapy for active cases awaiting Sanatorium admission?

ANSWER: The answer to that is yes and no. There are a certain number of cases in whom by proper selection I believe the drug could be substituted in the home as a part of the long range plan. There is no one thing in Tuberculosis that is going to effect the cure. You have to effect a plan for each case. I have not quite reached the point where I believe that drug therapy should be given to everybody universally.

QUESTION: My second question is: Do you think it is the responsibility of the Federal Government to arrange for or subsidize the care of the Tuberculosis transient who has no legal residence?

ANSWER: I'm going to give you a very definite, emphatic NO. Maryland has at the present time three displaced persons hospitalized under the care of the taxpayers of Maryland. The Federal Government after they come in assumes no responsibility. The oldest one of that group being in Maryland a period of six months before hospitalization was necessary. The youngest one was a period of one month. So it is easy to say to somebody else give me the money; but that money comes from taxation and by the time it comes back to us it is going to cost us a whole lot more. I think as the States assume their own responsibilities and carry on, it is going to be beneficial to all of us not only from the prospect of carrying our own program but also from the problem of paying taxes. I am allergic to taxes.

QUESTION: My third question is: What can we do with the recalcitrant active case who has refused or resisted hospital admission in spite of adequate social service and psychiatric attention?

ANSWER: At the present time there isn't a great deal we can do. I mentioned the one law in Maryland, I think it is called Public Law 57. I know several years ago in one of the large, very large cities north of us, there was a Quarantine Law, quarantining patients with Tuberculosis to a City Contagious Disease Hospital. All that an individual who had Tuberculosis had to do to be admitted to a hospital—and many of them did want to—was to appear on the street and expectorate in the gutter or some place and have some friend of theirs lodge a complaint. By some court order they were quarantined and then they were eventually transferred into a Tuberculosis institution of that State. That City has been rather well taken care of at the sufferance of the rest of the State. We in Maryland do not have a sufficient number of beds, balanced, staffed etc., to have such a law on the books at the present time. Smallpox is almost extinct. There is only an occasional death from smallpox; there are many thousand deaths from Tuberculosis per smallpox death due to two things, vaccination plus compulsory isolation. It is going to depend entirely on the attitude of the public and the medical profession and

the State Board of Health as to whether or not there will ever be recommended a law of compulsory hospitalization or isolation in this State which has any teeth in it. I personally believe that if such a law were on the books it would need to be used seldom because the person who carries a big stick and doesn't use it very often usually carries a great deal of authority.

DR. BARNWELL. I was curious about your statement on the waiting list. I don't know of any other area where there is so much discrimination made between sexes and bars of democracy as with Marylanders.

DR. HETHERINGTON: We cannot put them both on the same floor for some reason.

JUDGE WAXTER: I have a question which reads:

QUESTION: Why is the Baltimore City Hospitals under the Department of Public Welfare instead of the Health Department?

ANSWER: The reason I imagine is entirely historical. It seems the Baltimore City Hospital is the end result of an evolutionary development that began so far as we know in 1771, or 180 years ago, when they first established an Alms House for Baltimore Town; Baltimore City Hospitals is the great, great grandchild of that Alms House. Whether it should be with the Department of Welfare is quite a different thing. Municipal hospitals are set up in four different ways. In Cleveland the Health and Welfare Department is one Department under a single administrator. In New York they have a separate hospitals division of the City government. In Philadelphia they have their hospitals under the Welfare Department. In Washington they have their hospitals under the Health Department. The proof of the pudding is which of these hospitals represent the best institutions giving care to the patients, and having visited a number of the hospitals in the various cities throughout the country, you just can't come to any real conclusion. For instance in Maryland the State Tuberculosis Hospitals are under the State Health Department; the one Municipal institution of 450 beds at Baltimore City Hospitals is under the Welfare Department. Now you'd have to go in and make a study of those two systems to find out in which institution is the patient receiving the better care. Where is the level of care involved? Finally you have this situation. In the Baltimore City Hospitals, policy is determined by a Medical Advisory Board consisting of the Chiefs of the various services in the hospital; the Deans of the two Medical schools; the Director of Health, and the Director of Welfare which is where it should be. Where an institution should belong in any community depends upon where you can put it and get the highest standard of care for patients.

DR. BARNWELL: Thank you, Judge Waxter. These questions haven't turned out to be as difficult as I expected. I expect that is through the talent of the panel. Now, Miss Dooley.

QUESTION: My question is, "Why do nurses generally refuse to accept a Tuberculosis case?"

ANSWER: Changed a little bit, Why do nurses generally refuse to accept an assignment in caring for patients with Tuberculosis, my answer is that Tuberculosis nursing is not part of the basic curriculum in Schools of Nursing, and nurses reluctantly go into an area of nursing where they feel inadequate. Dr. Langeluttig spoke at some length about teaching Tuberculosis in the Medical schools. Traditionally, nurses tie themselves to the progress that is made by the doctors, and I think that as the doctors begin to develop this program in their own training programs that it will be easy for the Nursing Schools to follow. The second thing is the nature of the disease and the treatment offered the patient has not been particularly attractive to nurses in the past. And the third is the location of the hospital is usually away from the centers of professional activity and from recreational facilities, and

nurses are reluctant to isolate themselves from these activities.

DR. BARNWELL: Now, Judge Waxter pointed out some of these questions involved not only medical science but political, social science, and administrative skills. I think Dr. Robinson is willing to admit this question is absolutely relevant from the point of view of medical science and may hit on some of the others.

DR. ROBINSON: The first question is:

QUESTION: Would a single Tuberculosis control office for City and State make for greater efficiency, and if so how could this be accomplished?

ANSWER: I suppose I am asked that question because I'm unofficial. I should say categorically without giving any reasons that a single Tuberculosis Control office of the whole State would be more efficient in some ways. How to bring this about would be to fuse the Baltimore City Department of Health with the State Department of Health. I think the Baltimore City Health Department, historically is much older than the State Health Department and I don't think that there are situations in this country where there is more autonomy in a city in relation to the State as in Baltimore. The Baltimore City Health Department certainly if it is going to exist, must have a Department of Tuberculosis; whether the efficiency between the State and City can be increased is a matter of administration and cooperation. The Commissioner of Health in Baltimore City is on the State Board of Health and there seems to be a very definite cooperation and teamwork between the City and State, but it does create some difficulties in Administration. I don't think there is any way to accomplish a fusion unless it be very radical which is not going to happen. Now the other question.

QUESTION: How many Social Service Rehabilitation workers are there working in the Baltimore area; how many are needed and what prospects are there of getting them?

ANSWER: Well, for the whole State, there are seven professional social workers in the field of Tuberculosis. I won't go into just the city because they are brought together. The social work in Maryland is headed by the social work consultant in Dr. Hetherington's Department, the Bureau of Tuberculosis, and there are four social workers doing hospital social work, three on his staff and one on the staff of the Maryland Tuberculosis Association. There is one social worker in one Baltimore clinic and there is a Social worker in the Tuberculosis Division of Montgomery County Health Department, so there are only seven in the whole State. We need one social worker for every one hundred patients, that is, we ought to have at the present time ten, at least in the State Hospital and about four or five in the City Hospital. There is a social worker in one of the private hospitals, I think in Mt. Pleasant and Eudowood is interested in having a Social Worker added. There is a great deal of interest and this whole matter is going ahead. Now, as for rehabilitation, there are two people on the Rehabilitation Staff who are concentrated on Tuberculosis. One covers the State Hospitals. She does practically nothing but Tuberculosis but gets a great deal of cooperation from all the other members of the Rehabilitation Staff of the State. The other one is the Rehabilitation worker in Baltimore City who spends a considerable part of her time working with the Tuberculosis patients in the City Hospital as that also is part of the State service, or State Vocational Rehabilitation Service of the Department of Education. All these things are, as I said, demonstrations and by no means are these services complete here or anywhere else unless it is at some of Dr. Barnwell's hospitals.

QUESTION: (BY DR. SAUER:) My first question is: Is puberty still the most dangerous age for getting Tuberculosis?

ANSWER: I think this must be under the heading of "leading questions." It is not; if one inter-

prets the getting of Tuberculosis as getting Tuberculous infection. Infancy I believe always has been the most hazardous period for survival following infection. The question may be answered in reverse. There are evidences that childhood, the period between say five and fourteen is probably the safest age at which to be infected. Although the age of death is shifting and has shifted in to older age groups quite rapidly particularly among males, still there probably isn't too much to choose, so far as the optimal age of infection is concerned.

QUESTION: My second question is: Last year there were 500 deaths and 1400 cases reported in Baltimore City, how many cases would you estimate are undiagnosed?

ANSWER: I'm afraid this is an unanswerable question. I'm quite sure for one thing, ratios that have been set up are generally not applicable. For instance if one tried to establish a ratio between mortality and disease, it might hold for "whites" and not for negroes in whom the problem is a different one for perhaps a number of reasons. There has been a belief, as you know, or an idea, a very ancient one, in that it arose at the time of the Framingham survey back around 1918. Perhaps I shouldn't describe that as ancient, but a view that there were perhaps nine or ten cases of tuberculosis in the community for each annual death. Now that is an attempt to relate an incidence of mortality, a rate of dying to a prevalence of disease. That survey was based on the crude methods then available. X-ray was not a part of it; surveys that have been done since seem to indicate that they weren't so far off the mark. As for relating the number of deaths to the number of new cases in a given year which is that of relating a rate to a rate, I don't believe it can be done, because you'd first have to define a case and decide when the individual became a case. That is almost an impossible definition. However, it has been true that the community surveys were a more effective case finding mechanism and active programs have had a higher ratio of new reported cases to deaths than one would expect. That is one sort of a measurement.

QUESTION: Is the incidence of tuberculosis higher among nurses working in general hospitals as compared to those working in a tuberculosis sanatorium?

ANSWER: Again, an answer is difficult because many student nurses enter the institutions uninfected. They definitely have a higher risk of tuberculosis than graduate nurses. Student nurses as a rule do not spend much of their time in Tuberculosis Sanatoria, they may affiliate there but that is all. There are a few sanatoria that maintain programs for student nurses, so that you have difficulty in comparing. However, my answer to that would be that in institutions where the teaching and the care for proper techniques are sound, that the risk is pretty small in either event. I think perhaps Miss Dooley would like to comment on that.

MISS DOOLEY: Well, the danger lies in working in facilities that are not adequate to carry out isolation techniques. It has been my experience that well run hospitals have had a relatively low incidence of tuberculosis. I'd like to ask the Moderator about the comparison of tuberculosis in Tuberculosis Hospitals, General hospitals and psychiatric?

DR. BARNWELL: If you want the Veterans Administration experience, we have very few student nurses. There are a few places where we do have affiliation programs but taking personnel as a whole, including the nurses, there is no difference in our several types of hospitals. They are divided into General hospitals, Neuropsychiatric hospitals and Tuberculosis hospitals and the incidence runs about one-tenth of one per cent; there is no difference in those hospitals. Mr. Weiss, your question?

MR. HARVEY WEISS: The question as described, is an ideal situation but the fact remains the General hospital places many barriers in the

path of the patient with Tuberculosis who needs temporary hospitalization.

QUESTION: Are the Superintendents of General hospitals locally facing up to this situation?

ANSWER: Well, the answer to that is no, they are not. I do want to say in their defense though, that temporary hospitalization in the eyes of a superintendent in the Tuberculosis hospital is rather a relative term when compared to temporary hospitalization in the general hospital. It is like the visit of a mother-in-law; I mean you never know how long they are going to stay. Temporary hospitalization might mean months, and if you take what Dr. Silverman and Dr. Hetherington said, it could mean a long time. Once people get into General hospitals and they have to go back home, the chances are that they either don't want to go home or they won't go into a special hospital. But, I'm sorry to say, General hospital superintendents in Baltimore area are not facing up to the situation. That's an honest answer to this question.

DR. BARNWELL: Now the question from Dr. Langeluttig.

QUESTION: My first question is, how many hours are devoted to Tuberculosis in the local Medical Schools?

ANSWER: I can speak only for the University of Maryland Medical School and say that the Junior students receive between twelve and sixteen hours of didactic lectures devoted entirely to Tuberculosis. Now in addition, of course, they receive didactic lectures regarding other diseases of the chest and occupational diseases of the chest. However, there is very little if any practical work on Tuberculosis wards. City Hospital is not utilized except for the teaching of physical diagnosis.

QUESTION: My second question is, do you practice what you preach as far as the program for early case finding among student nurses and house staff?

ANSWER: Again at the University of Maryland Medical School students and nurses are X-rayed and have tuberculin tests done on admission to the respective schools. If they are tuberculin negative they are followed by tuberculin tests at regular intervals, and of course if they should turn positive during their period of training they are then X-rayed and followed very carefully. Those students who come into the school with a positive tuberculin test are X-rayed at regular intervals. Now, the House Staff of the University and Mercy Hospitals are X-rayed. I can't speak of other hospitals from personal knowledge, except at City Hospital they also carry out that policy. In addition we have a policy of offering BCG vaccination to intern and staff nurses who are tuberculin negative. That is not compulsory in any sense of the word. We simply state to the individual what our knowledge is, what our feeling is about the matter and let them make their own decision.

DR. BARNWELL: Thank you, Dr. Langeluttig and now Dr. Sauer.

QUESTION: Do you think it is possible to get the cooperation of the Press in avoiding premature dissemination of information about unconfirmed cures?

DR. SAUER: I'm a great believer in freedom of the Press and I think the Press should not be restricted in terms of publication. Now, when is a cure going to be confirmed or unconfirmed? There are many things I read in the newspapers which I don't believe; sometimes I read one thing and on the next page I read something else and the next night I'll read something else and there must be a little fib in it somewhere because they can't all be telling the truth. Maybe some are telling a part of it and maybe all are telling none of it. I don't know. I think the Press does cooperate in a certain sense that the more vicious of these unconfirmed cures where a person is out for personal profit are not published. If you would look through some of the publishing in the paper of 1890 and what you will see in the paper today, you will realize that the Press has suppressed a goodly portion of the really vicious type of cures.

Now, if a person has a premature release in order that there is some financial gain to it, then I would say that something can be done through the A.M.A., as far as that doctor is concerned. However, I might feel that a project is half baked and not ready for publication at all; one of you might be working on the same thing and might say it is completely ready for publication. Who is to judge? If a man thinks that he should publish and that he has the necessary information, I would say let him go ahead and publish and let us do the judging. If he is publishing for gain, financial gain or something of that nature, then by all means I think we do have the power to at least censure him.

How often are doctors and drug firms at fault? Well, sometimes doctors are at fault and again I think I have stated what I think about doctors. Occasionally there will be two drug firms working on a product. The drug firm that publishes first, say they have a terrific advantage for the next twenty years. It is up to the other fellow to catch up to them. Occasionally a drug firm does publish something which probably is premature. I know of no law that we have to hold back the drug firm.

DR. BARNWELL: I want to thank the chairman for his splendid organization and sense of timing; thank the members of the Panel for their contribution and thank the Faculty for their patience.

HOURGLASS PERINEURAL FIBROBLASTOMA ON THE CERVICAL PART OF THE VERTEBRAL COLUMN[1]

JOSEPH M. MILLER, M.D.,[2] JAMES G. ARNOLD, M.D.,[3] AND JOHN T. BRACKIN, JR., M.D.[4]

In a recent excellent article, Love and Dodge (1) point out that neurofibromas are the most common tumor affecting the spinal axis and frequently assume an hourglass shape. Other tumors which may occasionally assume an hourglass shape are fibromas, ependymomas, lipomas, enchondromas, meningiomas, hemangio-endotheliomas, ganglioneuromas, sarcomas and carcinomas. Chordomas, blastomycosis, echinococcosis and the commoner granulomas may also produce an hourglass lesion. The opportunity to treat an hourglass neurofibroma of the cervical part of the vertebral column in a patient, who had previously incurred a gunshot wound of the homolateral extremity with neurological deficit, presented an interesting problem.

[1] Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

[2] Chief, Department of Surgery, Veterans Administration, Fort Howard, Maryland.

[3] Consultant in Neurosurgery, Veterans Administration, Fort Howard, Maryland.

[4] Chief, Department of Radiology, Veterans Administration, Fort Howard, Maryland.

CASE REPORT

A 32 year old white male was admitted complaining of a painless mass in the left neck of three weeks' duration. The tumor had been found on a routine physical examination for employment.

The patient received a gunshot wound of the right forearm in 1945. Healing had occurred with partial injury to the right median and radial nerves, and partial loss of the soft tissues. Limited supination, pronation and extension of the right wrist, limited flexion of the fingers of the right hand and limited abduction of the right hand were present. Progression of the neurologic deficit had not occurred since the injury in 1945.

A non-tender, slightly movable mass measuring about four by five by four cm. was present just above the medial portion of the right clavicle (figure 1). The mass was moderately well fixed to the underlying structures and did not pulsate.

Laboratory examinations were negative. Roentgenograms of the cervical spine demonstrated smoothly eroded intervertebral foramina of the right sixth and seventh

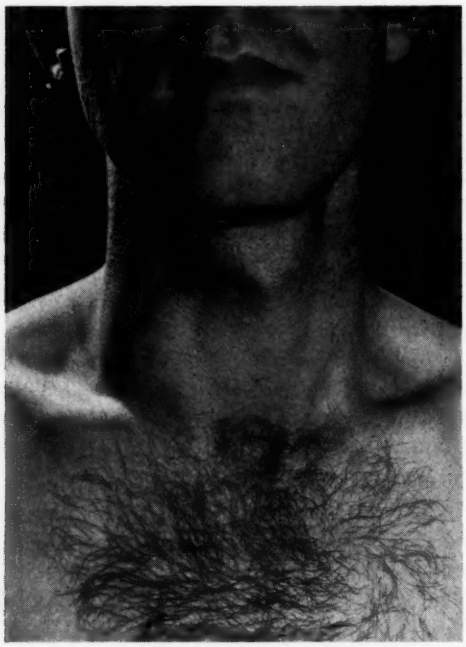

FIG. 1. Soft tissue mass in right lower cervical region.

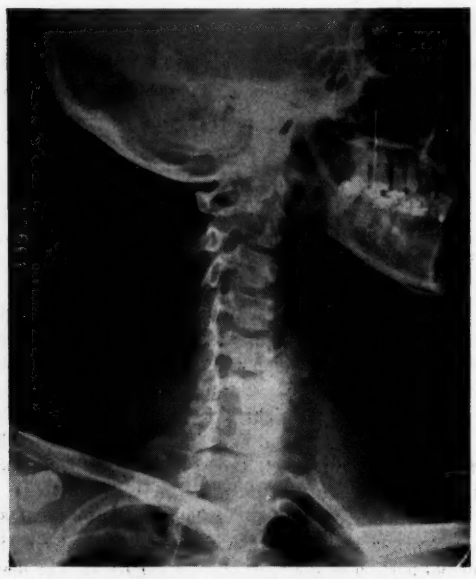

FIG. 2. Enlarged sixth and seventh intervertebral foramina.

cervical vertebrae (figure 2). Slight compression of the dura mater at the same level was demonstrated by the myelogram (figure 3) done with 12 cc. of pantopaque.

Subsequently, a two stage operation for removal of the tumor was done. At the first operation, a hemilaminectomy of the fifth, sixth and seventh cervical vertebrae was done. A completely encapsulated tumor was encountered and freed. The sixth and eighth cervical nerve roots were easily dissected free but the seventh was freed with difficulty and a portion of the capsule of the tumor was left. The distal portion of the seventh nerve root traversed the capsular portion of the tumor. The neoplasm was opened and curetted to decompress the mass. The tumor was not adherent to the dura mater but there was close apposition of the tumor to its lateral side.

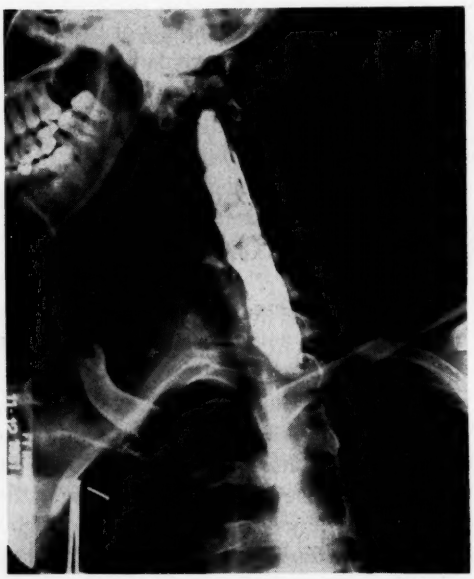

FIG. 3. Myelogram done with 12 cc. of pantopaque showing a smooth concave defect, and absence of filling of nerve cuff at the level of seventh cervical root.

Four days later an incision was made along the posterior border of the right sternocleidomastoid muscle. The muscle and the carotid bundle were retracted medially. The thin atrophic anterior scalene muscle overlying the tumor was divided. The phrenic nerve was retracted laterally. The mass was freed entirely and the seventh nerve root was left intact. A portion of the capsule was left on the nerve. Faradic stimulation of the nerve showed the conductivity to be intact and further dissection of the root was not done. A Penrose drain was inserted. A spinal fluid fistula from the posterior wound was noted in the postoperative period. This was controlled by removal of spinal fluid and aspiration of a collection of fluid at the site of the wound. Micro-

scopic examination, by Jack M. Burnett, M.D., showed a loose network of connective tissue fibres in which there were elongated cells with typical nuclei. In some areas, palisades of elongated nuclei were seen. A diagnosis of a perineural fibroblastoma was made.

Comment

Because of the location of the tumor in the anterior part of the neck, the nature of the neoplasm was not suspected until roentgenograms of the cervical portion of the vertebral column were taken. The right median and radial nerve damage had not shown progression since the original injury and therefore, the tumor was not related to the neurologic deficit. How long the tumor was present is unknown.

The tumor can be classified in the third group of Love and Dodge as extradural and extraspinal. Of 60 hourglass neurofibromas reviewed by these authors, 26 were located in the cervical portion of the vertebral column. In these cases, the only symptoms were referable to root involvement. The patients usually noticed pain or numbness in the arm, hand or fingers. Signs of cord compression occurred frequently.

Summary

A large hourglass perineural fibroblastoma was successfully removed in a patient with a painless tumor in the posterior triangle of the right side of the neck just above the clavicle. The diagnosis was suspected after the oblique roentgenograms showed bony erosion of the laminae of the sixth and seventh cervical vertebrae. Myelography demonstrated the mild compression of the dura mater.

Reference

1. Love, J. G. and Dodge, Jr., H. W., Dumbbell (Hourglass) Neurofibroma affecting the spinal cord. Surg., Gynec. and Obst. **94**: 161–172 (Feb.) 1952.

PSYCHOSOMATIC MEDICINE IN GENERAL PRACTICE

E. PAUL KNOTTS, M.D.*

We are living in a fabulous age. The frontiers of medical practice have been conquered to an extent undreamed of by those of a generation ago. Diagnosis, of even obscure conditions, is often made easy by simple tests and treatment with resultant lives saved, disabilities removed and health and happiness substituted for death. Of equal importance, preventive medicine has all but conquered pestilences and plagues that, in the past, have changed the way of life of nations and have caused great nations to crumple and die. One of the wonders of our age is the speed with which new methods of diagnosis and treatment are adopted in the office of the most remote General Practitioner. This is one of the outstanding triumphs of organized medicine.

One field of medicine as ancient as man, preceding, in primitive forms, the written word, is now dignified by the mouth filling connotation, "psycho-somatic medicine." It represents a frontier that has not been pushed back and by comparison with the epochal victories over the Captains of the Men of Death, constitutes a reproach to our profession.

Perhaps this is true only because this field of medicine needs a new approach. It is my considered opinion that the great group of men and women who have dedicated their lives to the relief of pain and the curing of disease have the patience and the inclination to take over any task that means the alleviation of human frailties. Happiness is only achieved in service and the medical men can secure happiness in direct proportion with this concept. It is true that the diagnosis and prompt cure of pneumonia, typhoid fever and meningitis represents soul satisfying accomplishments, yet the quieting of a

* Denton, Md.

tempestuous household, the restoration of an alcoholic to sobriety, the saving of a potential suicide represents service that can be as dramatic as somatic victory.

The tremendous scope that psycho-somatic medicine includes might be indicated by mentioning a few of the conditions to be met. Alcoholism, colitis, fatigue states, allergies, lost libido, migraine, epileptic equivalents, tachycardias, and when the storm is severe, auricular fibrillation. Also chronic dyspeptics and even peptic ulcer, pruritis ani, and dermatitis. In no phase of medical practice does one escape the difficult differential problems presented by the psychoneurotic patient.

Paulson has said: "Only that which is obscure arouses passion, for evidence excludes individual choice." Inner unrest has been compared to pain. A toothache, at least, informs the victim of the source of his trouble. Pain is not the only sensation hard to bear. Everyone has known the sensation of fear, of apprehensions, of intolerable suspense in relation to personal situations. Some times such feelings are experienced without any realization of their origin. If anxiety is sustained and its source is not traced, the person experiences, not only distress, but the helplessness that comes from dealing with unknown rather than a known danger, frustration or pain.

The civilized person is presented with a world that has many savage implications, and yet so filled with taboos, personal, social, intellectual and spiritual, that conflicts can take place at such deep levels that he scarcely knows they exist. The effect of such conflict is obvious. There is anxiety, with its source mystifying to the patient and doctor alike. "Sorrow which has no vent in tears may make other organs weep." (Maudsley). If his symptoms had had behind them positive serology evidences of cerebral vascular accident, thyroid disease or some eye ground evidence of cerebral arteriosclerosis then the diagnosis would have been easy. When there is no pathology to be found even the symptoms may be missed because the inquiry did not elicit them. The study had been of the disease and not of the man who had the disease. The patient is dismissed with a prescription for phenobarbital, a pat on the back and goes on down the street to the chiropractor. Potential or mild psychoneurosis has now been aggravated and perhaps has become a fixed pattern.

Worse, might have been the finding by X-ray of a gall bladder which filled poorly with dye; a retroverted uterus; ptosis of some abdominal viscera; or in a much scarred abdomen have made the diagnosis of intestinal adhesions, lampooned by Osler as "the refuge of the diagnostically destitute" and referred the sick creature to a specialist for further surgery. One must remember that no disease of the abdominal organs can produce a psychoneurosis. That must arise in the brain.

The problem presented by psycho-somatic medicine cannot be delegated to specialists. There are not enough psychiatrists in the world and there never will be, to care for all the misplaced; constitutional inadequate personalities and the marginal psychotics. It is the responsibility of the general practitioner to be able to recognize incipient insanity and to secure consultation before the psychosis becomes a fixed pattern and so resistant to treatment that nothing remains but permanent commitment for custodial care.

Frequently the diagnosis of insanity can be made easily. Sudden changes in habits and personality traits; memory and insight failures; temper tantrums; phobias; depressive and euphoric characteristics; inability to concentrate; impaired judgment; moral degeneracy. The patient frequently may have some knowledge of his basic changes and in the presence of the doctor may be able to conceal his abnormal trends. Parents, children, neighbors and business associates may be invaluable in arriving at a diagnosis. Knowledge of siblings and family background which may contain numerous cases of the constitu-

tionally inadequate or even the insane may make it easier to understand and to adjudicate personality changes in the patient.

The treatment of psychosomatic states is akin to all afflictions of mankind. First is diagnosis. Realization that there is a lack of something in the brain that keeps most people well and unconcerned about health is important. Perhaps the brain is being used uneconomically with foolish worrying, silly thinking, conscience searching, jealousies, conflicts with people and riots of emotion. One must try to get these people to use their brains more gently in seeking happiness on less strenuous levels; to evoke basic changes in the patient's attitude; release anxieties, hostility and resentments; to reduce the pressures on the patient by getting the family, marital mate and others to understand the situation and to stop blaming the patient for inadequacies and failures.

The doctor must assist the patient to break monotonies, dissipation, overwork and to find consolation for sorrow and misfortune. The Priest, the Rabbi, and the Rector are willing and often able assistants. Some times, treatment must be by diverting the psychic directions, to become an extrovert by the medium of club work, church activities, delving into the arts as music, painting—or vocational pursuits such as carpentry, flower culture, masonry. Sometimes mental and emotional health can be brought under control only by removing such activities and prescribing rest periods and vacations.

In conclusion, the physician must successfully analyze the source of fatigue, neurasthenic and hypochondrical states, anxiety, resentments, self depreciation and frustrations, and institute treatment that will prevent the establishment of a fixed and permanent pattern of reaction to environment.

Great care must be exercised in discussing a diagnosis of organic disorders with the patient lest a potential psychoneurotic be spilled over into that unhappy state.

The recognition of incipient insanity and the prompt reference of such patients to a psychiatrist may result in preventing the deterioration of the patient into more grave psychoses.

Recognition and treatment of the bulk of the psychoneurotic states must remain the responsibility of the general practitioner.

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NEED AT ABERDEEN PROVING GROUND FOR A MEDICAL OFFICER AND FOR AN INDUSTRIAL SURGEON

At present there is an urgent need at Aberdeen Proving Ground for a Medical Officer and for an Industrial Surgeon. The salary of the Medical Officer (General) ranges from $7040 per annum to $8040 per annum and the salary for the Industrial Surgeon ranges from $8360 per annum to $9360 per annum.

Aberdeen Proving Ground is a permanent Army Post located in the Susquehanna River valley where this river meets the Chesapeake Bay. It is four miles off modern highway Route 40 midway between Baltimore, Maryland, and Wilmington, Delaware.

The Proving Ground has a beautiful, new-well-appointed ten room dispensary, staffed with two registered nurses, a clerk and a receptionist. The variety of jobs and the great diversity of mission at Aberdeen gives the progressive Industrial Surgeon a challenge that is both interesting and exciting.

For information write to Virginia P. Kirk, Employee Utilization Representative, Civilian Personnel Division, Headquarters Building, Aberdeen Proving Ground, Maryland, or telephone Aberdeen 1000, Extension 3113.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

The Allegany-Garrett County Medical Society held its meeting on Friday, December 19th at Memorial Hospital.

Dr. Ernest J. Fogel presented a paper entitled "Electroencephalograms and Their Contribution to Medical Diagnosis." Dr. Fogel is Chief of Neurology and Psychiatry at the Veterans Hospital in Martinsburg, West Virginia.

At this meeting, Dr. Samuel Jacobson presented a patient who has recently had a successful operation for mitral stenosis and had a satisfactory recovery.

Dr. Benedict Skitarelic, Cumberland, gave a lecture on "Hematology" and "Venipuncture, Infusions and Hypodermoclysis" at the Civil Defense nurses training program session held recently in Cumberland. This was the second in a series of lectures, the first being "The Role of the Nurse in Mass Handling of Casualties in Time of Disaster" delivered by Dr. A. J. Mirkin.

Dr. L. R. Meyers, Cumberland, is in Florida vacationing at his orange grove near Fort Lauderdale, for two months.

DR. CHARLES L. OWENS

Dr. Charles L. Owens, 305 Washington Street, Cumberland, now retired, was happily surprised by some of his close physician friends of many years. Some whom he had been closely associated with, but many whom he had been the family adviser for their families. Charlie had delivered their babies and cared for their wives, sisters and children these many years and did it well. At Christmas, they brought with them a lovely Television set, for Charlie to use and while away the time when he isn't writing his memoirs for posterity.

Dr. Owens was always the kindhearted kind of the old school, a delightful bedside manner and a true friend. His smile has never left his face, even though he has been confined to his room these past years. Never losing his interest in medicine and loves to talk it over to the steady trek of his professional friends, who never miss a day in dropping in to chat. He graduated at Maryland University in 1904 and has been happily married for 45 years to the former Betty Ann Edwards.

Dr. Owens would love to have his old classmates write or drop in on him sometime.

DR. GEORGE MURRAY SIMONS

Dr. George Murray Simons, LaVale, is the first Cumberland area physician to receive orders for induction into the armed forces under Selective Service regulations.

P. Emmett Fahey, clerk coordinator of draft boards here, said Dr. Simons will report December 30 in Baltimore for military duty.

Following a pre-induction physical examination some time ago, Dr. Simons was placed in Priority 2—medical men educated at government expense and with less than 20 months of active service.

During World War II, Fahey said, doctors and dentists entered service under a procurement system not covered by Selective Service Laws.

Born in Rainsburg, Pa., Dr. Simons came here with his parents at the age of one month. He attended public schools and was graduated from Pennsylvania Avenue High School. He entered the Army soon after graduating from the University of Maryland School of Medicine in September, 1944.

Dr. Simons served in the transport command on the Pacific Coast for about two years and was discharged with the rank of captain. He completed his internship at University Hospital, Baltimore, and also was assistant resident physician there.

Later Dr. Simons returned to Cumberland and served as resident physician at Memorial Hospital for six months, resigning August 1, 1948 to begin his private practice here.

Dr. Leon A. Kochman, a native of Cumberland, now practicing in Baltimore, conducted an arthritis clinic here Friday, December 5, through the auspices of the Allegany-Garrett County Medical Society. Dr. Kochman was at the Allegany County League for Crippled Children's Building from 9 a.m., until noon, and was available for private consultation

at Memorial Hospital by appointment, from 1 until 5 p.m.

Recently Dr. W. Royce Hodges, spoke to the Allegany-Garrett County Medical Society and reported 5,000 obstetric cases with an analysis of the different methods of anesthesia used. Twenty one hundred were given continuous caudal analgesia. Four hundred received continuous spinal anesthesia and saddle block, while the rest were managed by the so called natural childbirth and the usual anesthetics.

The cases dated over a period of the past ten years, 1942 to 1952.

Baltimore City Medical Society and its Sections
Meetings will be held at 1211 Cathedral Street unless otherwise stated

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BALTIMORE CITY MEDICAL SOCIETY

WETHERBEE FORT, M.D., *President* — EDWARD F. COTTER, M.D., *Secretary*
LEWIS P. GUNDRY, M.D., *Vice-President* — ROBERT C. KIMBERLY, M.D., *Treasurer*

Friday, March 20, 1953, 8:30 p.m.

SEMINAR: RECENT ADVANCES IN RADIOLOGICAL STUDIES OF THE VASCULAR SYSTEM

Charles T. Dotter, M.D., *Moderator*, Professor and Chairman, Department of Radiology, University of Oregon Medical School, Portland, Oregon.

Participants

Pulmonary Angiocardiography. Israel Steinberg, M.D., New York City.
Peripheral Angiography. E. Converse Peirce, II, M.D.
Cerebral Angiography. John W. Chambers, M.D.
Angiocardiography. Charles T. Dotter, M.D., *Moderator.*

OPHTHALMOLOGICAL SECTION

ANGUS L. MACLEAN, M.D., *Chairman* — HAROLD C. DIX, M.D., *Secretary*

Thursday, March 5, 1953

Cocktails 6:15 p.m. Dinner 7:00 p.m.

Glaucoma. Paul Austin Chandler, M.D., Boston, Massachusetts.

CANCER SECTION

EDWARD F. LEWISON, M.D., *Chairman* — ROBERT N. COOLEY, M.D., *Secretary*

Wednesday, March 11, 1953, 8:00 p.m.

The National Institute of Health, Bethesda, Maryland

Dr. John R. Heller, of the National Institute of Health, is arranging this meeting. The program and exact meeting room will be announced later.

A cordial invitation is extended to *All* members of the Medical and Chirurgical Faculty.

CANCER SECTION

ROBERT N. COOLEY, M.D., *Secretary*

The first meeting of the Cancer Section of the Baltimore City Medical Society for the current academic year was held at the National Cancer Institute on Friday evening, October 3rd. Dr. J. R. Heller, Director of the National Cancer Institute of the National Institutes of Health, was responsible for arranging the program and the members of the section are indebted to him and his colleagues for an interesting and instructive meeting.

Most of the Baltimore group did not arrive on the grounds of the National Institute of Health in time to obtain a daylight view of the New Clinical Center Hospital. However, it is a massive and impressive structure of fourteen floors and is now nearing completion. It is expected to start receiving patients on April 1, 1953.

Dr. Heller, the first speaker on the program, described many of the extensive facilities which will be found within the new hospital. Primary attention will be given to those diseases which are now the major cause of mortality and chronic ill health among the American people and emphasis will be placed on basic research; therefore, a predominantly large area of the hospital will be given to laboratory space. A basic laboratory unit or module has been designed which it is believed will be very flexible in operation. It consists of an area 12 × 20 feet in dimension in which partitions can be arranged to suit the needs of the particular investigation which is to be carried out. These modules are in close physical relation to the patient area and are almost autonomous in their operation. The hospital will ultimately contain approximately one thousand such units.

In addition to the extensive laboratory facilities, there is ample space devoted to the clinical examination, care and treatment of patients. The standard nursing unit is designed to take care of twenty-six patients. These twenty-six patients will be housed in two bed wards, each of which has an adjacent toilet and bath. All rooms are air-conditioned and are outside rooms. Much attention has been given to such details, as easily maneuverable beds; hand rails for ambulatory patients are present throughout all the corridors; door widths are ample and such items as a new model bedside lamp have received attention. Indeed, it is impossible in a short space to outline all the developments and facilities which the hospital contains. Needless to say, it will provide the most advanced type of hospital facilities now known.

The total capacity of the hospital under normal conditions is expected to be five hundred patients. Of these, one hundred and twenty-five beds will be devoted to cancer research and one hundred beds to research of diseases of the heart. An interesting feature is that the capacity of the hospital can be expanded under emergency conditions to receive upwards of three thousand patients. The hospital could therefore be quite useful in case of a catastrophe or local emergency. Patients will be accepted only upon reference from their attending physicians. The sole criterion for acceptance or admission is that the patient be suffering from one of the conditions under investigation in the center at that particular time.

A second paper of the scientific program was presented by Dr. Harold P. Morris on "The Experimental Production of Malignant Thyroid Tumors by the Administration of Thiouracil."

Thiouracil when administered to mice depresses the activity of the thyroid and brings about a compensatory increase in secretion of the thyro-tropic hormone of the pituitary. The thyroids of a certain strain of mice (C 3 H.) under such treatment showed enlargement, and thyroid metastases were found in the lungs. If a portion of the thyroid or of a lung metastasis in these animals is transplanted subcutaneously to mice of the same strain who are also under the effects of Thiouracil, these transplants will continue to grow. After four transplants in one instance, a lung nodule developed which after the seventh transplant became completely autonomous and was able to grow in the tissues of normal mice. A second series of transplants from the thyroid of another animal produced in the ninth generation a tumor line which grew autonomously in normal mice, but which grew much more rapidly in mice fed on Thiouracil. Histological studies in both series of transplants revealed a gradual transition of the normal thyroid into an adenomatous type of tissue with some evidence of malignancy. Apparently two different tumor strains were produced. The differences in these strains consisted in: 1) histological structures; 2) size; and 3) ability to assimilate Iodine 131. There

was thought to be considerable correlation between the histological appearance and the degree of malignancy of the tumors.

A third paper on "The Production of Carcinoma of the Cervix Uteri in the Experimental Animal," was presented by Dr. Edwin Murphy.

Carcinoma of the cervix is rarely seen in animals. In 1938, Allen reported an unmistakable cervical cancer in a mouse, produced by the prolonged use of estrogen. Also, a strain of mice which in England were highly susceptible to osteogenic carcinoma, upon being removed to New Haven, Connecticut, began to develop carcinoma of the cervix with frequency. However, this same strain when housed at the National Cancer Institute did not produce carcinoma of the cervix.

Because of this failure to produce carcinoma in the experimental animal with regularity, Dr. Murphy explored the possibilities of producing the tumor by exogenous or extrinsic factors such as the local application of an acetone solution of methyl-cholanthrene directly to the cervix of mice. Dr. Murphy modified an otoscope for use as a vaginal speculum and, no doubt, he became quite proficient in applying his carcinogenic agent directly to the cervix. After a latent period of about nine months, approximately one-third of the exposed animals developed a carcinoma of the cervix. Later, about 50 per cent of the exposed animals could be made to develop a carcinoma which was similar in most respects to the disease as it occurs in humans. Histologically, the tumors are squamous cell carcinomata somewhat more cornifying than the average human cervical cancer. These tumors invade the pelvic structures, particularly the rectum and bladder, producing blockage of the ureters, resembling in considerable detail the human disease. Pulmonary metastasis has been demonstrated microscopically, but lymph node metastasis has not.

The availability of numbers of experimental animals with cancer of the cervix has opened up new fields of study. Dr. Murphy has found that Papanicolaou examination of the vaginal secretions shows evidence of malignant cells about one month before any grossly detectable tumor appears. Furthermore, when the cancer is well developed abundant desquamated cells appear in the secretions. Several carcinomata in situ like lesions have been observed. Many other aspects of both development and treatment of the disease are now susceptible to investigation in the experimental animal.

Following the reading of the papers there was a short social hour with refreshments.

RADIOLOGICAL SECTION

H. LEONARD WARRES, M.D., *Secretary*

At the last meeting of the Radiological Section of the Baltimore City Medical Society, Dr. William Harris, Chief of Radiotherapy at Mt. Sinai Hospital, New York City, delivered a highly stimulating and provocative paper on "Carcinoma of the Larynx and Laryngopharynx."

At his institution, X-ray therapy is the treatment of choice for the above-mentioned malignancies, and they have now treated 139 patients from 1931 to 1947, inclusive. Their absolute five-year cure rate was 48%, and their absolute ten-year cure rate was 41%. These results were comparable to those obtained elsewhere with surgery; however, utilizing radiotherapy, the larynx was maintained intact.

The discussants were Dr. Edwin N. Broyles, Associate Professor of Otolaryngology at The Johns Hopkins Hospital, and Dr. Grant E. Ward.

BALTIMORE COUNTY MEDICAL SOCIETY

DONALD L. SOMERVILLE, M.D.

Journal Representative

A recent meeting of the Baltimore County Medical Association was held at the Stafford Hotel. This was a joint meeting with the Woman's Auxiliary, and thus was of course one of the more pleasant meetings of the year. The guest speaker was Dr. Henry J. Marriott, Assistant Professor of Medicine at the University of Maryland School of Medicine. His interesting talk centered about the subject of Recent Milestones in Medicine, and pointed out the fact that there are three main mechanisms responsible for medical discoveries, so to speak: Flukes, Ingenuity, and Plodding. Examples of the first of these include the eventual development of Dicumarol from the investigation of cattle deaths 25 years ago, a story now familiar to all, and Fleming's wind-borne discovery of Penicillin. Dr. Marriott felt ingenuity

was responsible for such milestones as Dr. Taussig and Dr. Blalock's collaboration on cardiac surgery, the eventual use of British Anti-Lewisite for a purpose foreign to its original development, and so forth. Plodding had led to the discovery, and is now leading to more discoveries, of antibiotics from the common soil; Dr. Marriott reminded us that the Bible pointed out the way in this last endeavor, quoting from Ecclesiastes: "The Lord hath created medicines out of the earth." Many important milestones in medical progress were touched upon, such as B_{12}, ACTH and Cortisone, the Rh factor and blood factors generally, antimalarial drugs, and the interesting change in attitude toward and treatment of Leprosy. Finally, some of the undesirable "by-products" of great discoveries were indicated, such as those arising from over-enthusiastic use of antibiotics: Sensitizations, interference with immunity, bacterial resistance and dependence, superinfections, and antibiotic antagonism.

A brief business meeting concerned itself primarily with the announcement by the Nominating Committee of the choices they had decided upon for next year's officers: President, Charles F. O'Donnell; Vice-President, Martin E. Strobel; Secretary-Treasurer, Thomas E. Wheeler. The delegates nominated are the same as the current year, Drs. David H. Andrew, James G. Howell, and Melvin E. Davis. Dr. Paul Royse spoke in behalf of the Medical Education Committee regarding the need for contributions to the American National Education Foundation, and it was moved that the Society as a whole contribute $100.00. Dr. Royse reminded the members that every dollar contributed is matched in effect 2 to 1 by the Foundation itself.

CARROLL COUNTY MEDICAL SOCIETY

WILBUR H. FOARD, M.D.

Journal Representative

The Carroll County Medical Society met at Hoffman Inn in Westminster, and after dinner Dr. Newland E. Day, of Baltimore, representing the National Foundation for Medical Education, made a special plea for the support of medical schools through this foundation. He went on to say that if we didn't support such a program we may have more Federal control of our Medical Schools.

Mr. Walter Kirkman, from the Medical and Chirurgical Faculty, advised us concerning legislative matters that may come up and urged us to cooperate and support the State Medical Society, as they endeavor to look out for our best interests.

Our guest speaker was Dr. John Wagner, from the University of Maryland School of Medicine, Department of Neuropathology. He gave a very interesting and informative talk on the neuropathological aspects of many diseases. Dr. Wagner illustrated his talks by showing many slides from cases from the University.

Carroll County's new $122,000 Medical Center, a memorial to the County's veterans of both wars, was dedicated at Westminster, Armistice Day.

The new Medical facilities have been planned both functionally and architecturally as the first unit of a future hospital for the County.

Governor McKeldin, who attended the ceremonies with Mrs. McKeldin, gave the principal dedication address.

Funds for construction of the center were donated by citizens of the County during 1943 and 1951. Additional funds were received from the Federal and State governments and the Commissioners supplied $7000 and will take over maintenance and care of the new building.

It was announced that a fund is now being accumulated by the County Commissioners that will, together with Federal aid, provide a minimum of $300,000 for hospital construction within the next few years. It was estimated that the building which was dedicated today will save $75,000 to $100,000 in the construction of a hospital.

Dr. Neal Gordon, County Health Officer, and his staff conducted the visitors, including the Governor and his wife, through the spacious, well lighted clinic and health offices.

Beneath the bronze plaque in the Memorial lobby, a bronze covered log has been installed bearing the names of those Carroll Countians who served in both wars.

Furnishings for the lobby have been donated by a Westminster Service Club.

HARFORD COUNTY MEDICAL SOCIETY

CHARLES R. HAYMAN, M.D., *Secretary*

The following are the minutes of the Harford County Medical Society, held on December 21, 1952.

Members present: Doctors Barthel, Hayman, Hudson, McDonald, Norment, Phillips, Rodman, Sandecki and Stansbury.

Old Business: 1. *Routine X-ray for patients entering Harford Memorial Hospital.* The committee presented this request to the hospital board, with an offer from the Tuberculosis Association to pay for X-rays of indigent patients. The board rejected the proposal.

2. *Chest X-ray for prenatal patients.* In view of the above decision, the Society voted that private patients (with low incomes) may be referred to the Health Department for this service. The doctor is to set the fee—from $2.00 to $5.00, depending on the income.

New Business: 1. *Maryland Heart Association.* In the majority of opinions a heart clinic is not needed locally. However, the association is to be asked to provide for indigent and medically indigent patients: transportation to Baltimore clinics; payment to Harford Memorial or County Health Department for EKG's, cardiac X-rays, sedimentation rates, etc.

2. *Medical and Chirurgical Faculty.* The following resolution was made by Dr. Phillips, seconded by Dr. Rodman, and unanimously passed: "That the Medical and Chirurgical Faculty be asked, when appointing committee members from Harford, to clear such appointments through the county society with approval of the county president."

3. *Election of officers for 1953.* President—Robert A. Barthel, Jr.; Vice President—Dudley Phillips; Secretary-Treasurer—Charles R. Hayman; Alternate Delegate—Richard C. Norment, 3rd; Delegate —Peter P. Rodman.

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THE DR. JACK W. KOLSON MEMORIAL LECTURE

sponsored by the House Staff of Sinai
Hospital of Baltimore, Inc.

Speaker: DR. GEORGE W. THORN
Professor of Medicine
Harvard University School of Medicine

STUDIES OF THE ADRENAL CORTEX

Friday evening, April 17th, 1953, 8:30 P.M.
Hurd Hall, Johns Hopkins Hospital

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ANNOUNCEMENT OF CONSULTANT TO THE EDITORIAL DEPARTMENT OF THE WILLIAMS & WILKINS COMPANY

It is announced by The Williams & Wilkins Company, medical publishers of Baltimore, Maryland, that effective with January 1953 Dr. Henry J. L. Marriott will become consultant to their editorial department.

Dr. Marriott is Assistant Professor of Medicine at the University of Maryland School of Medicine and is the author of a recent popular book, published by The Williams & Wilkins Company, entitled, "Medical Milestones."

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BOOKLET AVAILABLE—"ACCIDENT AND HEALTH COVERAGE IN THE UNITED STATES"

The Health Insurance Council annually publishes a booklet, "Accident And Health Coverage In The United States," which contains the results of the survey conducted on the subject. This booklet contains valuable information, and if you wish to order copies, it is suggested that you write to Richard J. Eales, Health Insurance Council, 488 Madison Avenue, New York 22, New York.

Library

NEW APPOINTMENT

We welcome to the Library Staff Mrs. Henry Berge, a graduate of the State Normal School at Towson, and of the Enoch Pratt Free Library Training Class. She has had a number of years experience in professional library work at the Pratt Library, in the public schools, and at the Park School, and comes to us well recommended.

With Mrs. Berge and Mrs Eleanor Kohler, who has been here several years, as assistants to Miss Wheeler, the Library should be able to continue its tradition of good service.

A SELECTED LIST OF PUBLICATIONS RECENTLY ADDED TO THE LIBRARY

Adler, Francis H., Physiology of the eye. 1951.
American College of Surgeons, Surgical forum. 1952.
Armour Laboratories, Physiological basis for the action of ACTH in human beings. 1951.
Army Medical Library catalog, 1950 & 1951.
Bachman, George W., Health resources in the United States. 1952.
Baer, Karl A. (compiler), Plasma substitutes. An annotated bibliography. 1951.
Beaumont, G. E., Recent advances in medicine. 1952.
Bland, John H., The clinical use of fluid and electrolyte. 1952.
Charnley, John, Closed treatment of common fractures. 1950.
Chew, Samuel C., Addresses on several occasions. 1906.
Cobb, Stanley, Foundations of neuropsychiatry. 1952.
Collins, D. H., Pathology of articular and spinal diseases. 1949.
Conn, Howard F. (ed.), Current therapy. 1952.
Duke University Bulletin. The first twenty years. A history of the Duke University Schools of Medicine, nursing and health services, and Duke Hospital, 1930–1950. 1952.
Elgood, Cyril, Medical history of Persia and the Eastern Caliphate. Cambridge, 1951.
Eller, Joseph J., Tumors of the skin. 1951.
Hayden Chemical Corporation, Neomycin. 1952.
Herbut, P. A., Urological pathology. 1952. 2 vols.
Howard, Marion E. (ed.), Modern drug encyclopedia and therapeutic index. 1952.
Institute for Research in Biography, Who's important in medicine. 1952.
Jordan, Edwin P. & Shepard, W. C., ℞ for medical writing. 1952.
Joslin, Elliott P., Treatment of diabetes mellitus. 9 ed., 1952.
Lederle Laboratories, Fifth year of aureomycin. 1952.
Longcope, W. T., Study of sarcoidosis. 1952.
Macalpine, J. B., Cystoscopy and urography. 1949.
Macht, David I., The holy incense. 1928.
Martin, Gustav J., Biological antagonism. 1951.
The medical directory, London, 1952. 2 vols.
Meyer, Adolf, Collected papers, vol. 4.
Meyer, Oscar D., That degenerate spirochete. 1952.
Newton, Sir Isaac, A descriptive catalogue of the work of Sir Isaac Newton. 1950.
Novak, Emil, Gynecologic and obstetric pathology. 3d ed. 1952.
Novak, Emil, Textbook of gynecology. 4th ed. 1952.
Plunkett, Richard J. & Hayden, A. C., Standard nomenclature of diseases and operations. 1952.
Quarterly cumulative index medicus, vol. 48, July–Dec., 1950, vol. 49, Jan.–June, 1951.
Rivers, Thomas N., Viral and rickettsial infections of man. 1952.
Smith, John, The pourtract of old age. London, 1676.
Soffer, Louis J., Diseases of the endocrine glands. 1951.
Stones, Hubert H., Oral and dental diseases. 1948.
Storch, Charles B., Fundamentals of clinical fluoroscopy. 1951.
Talbot, Nathan B., Functional endocrinology. 1952.
U. S. Federal Security Agency, Statistical studies of heart diseases. 1948.
Warren, Shields, Pathology of diabetes mellitus. 1952.
Watson, J. R., Hearing test and hearing instruments. 1949.
Williams, Ralph C., The United States Public Health Service, 1798–1950. Washington, 1951.
Winslow, C.-E. A., The cost of sickness and the price of health. 1951.
1951 Year book of drug therapy.
1952 Year book of general surgery.
1951 Year book of neurology and psychiatry.
1952 Year book of radiology.

Health Department

BALTIMORE CITY HEALTH DEPARTMENT

REPORTING OF OCCUPATIONAL DISEASES

At the request of the Dermatological Section of the Baltimore City Medical Society, Dr. R. R. Sayers, Senior Medical Supervisor for Occupational Diseases of the City Health Department staff, met with members of the group recently to discuss the revised occupational disease law. Particular attention was called to the fact that the law now covers all occupational diseases and not just the thirty-nine illnesses previously specified in the schedule.

This change was also emphasized in the report of the Committee on Industrial Health of the Medical and Chirurgical Faculty of Maryland, Nathan B. Herman, M.D., Chairman, from which the following is quoted:

"Most, if not all, occupational diseases are preventable through the cooperation of the physicians, industries and the health department. Recognizing this requires the physician attending or called in to treat a patient whom he believes to be suffering from an ailment or disease contracted as a result of the nature of employment to report the case to the State Health Department, or to the Baltimore City Health Department. The post card used for reporting communicable diseases is also used for reporting occupational diseases."

Members of the Dermatological Section requested they be supplied with the cards on which these reports can be made and the City Health Department is complying with this request.

The above procedures apply not only to occupational dermatoses but to all other occupational diseases equally. These diseases can be prevented through the cooperative effort of the physician treating cases which are, or he believes to be, due to the patient's work or working conditions. In making his report the physician brings into play the immediate cooperative action of the Health Department which works with industry in correcting unsatisfactory conditions thus preventing the occurrence of similar diseases.

Huntington Williams, M.D.

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WORLD MEDICAL ASSOCIATION SPEAKERS

Dr. Alfred Blalock, surgeon-in-chief at the Johns Hopkins Hospital, Baltimore, and Dr. Nicholson J. Eastman, obstetrician-in-chief at the Johns Hopkins Hospital, Baltimore, will be guest-participants in panel discussions at the First Western Hemisphere Conference of the World Medical Association at Richmond, Va., on April 24, 1953.

HEARING SCHEDULED ON EXTRA PAY ISSUE IN MILITARY SERVICES

Capitol Clinic, A.M.A., Vol. 3, No. 49, December 9, 1952

A subcommittee of a civilian commission established by the Armed Forces to study the question of extra pay for certain types of military duty (incentive pay, hazardous duty, overseas allowances, etc.) will hold hearings December 15 in Washington. Witnesses from private organizations will be heard and the question of the $100 monthly special pay for physicians and dentists in the Armed Forces is expected to come up. The American Medical Association has submitted a statement and requested to be heard at the hearings.

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, January 2–29, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARA LYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County	92	—	—	3	2	1	10	—	—	31	—	—	10	33	1	16	—	14
Anne Arundel	51	—	3	1	3	1	5	—	—	13	—	—	—	6	—	7	—	4
Howard	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
Harford	42	—	31	3	55	—	2	—	—	1	—	—	—	5	—	—	m-1	3
Carroll	1	—	2	—	2	—	1	—	—	—	—	—	—	1	—	3	—	2
Frederick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	1
Washington	11	—	—	—	—	—	—	—	—	1	—	—	—	7	—	3	t-1	4
Allegany	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
Montgomery	57	—	—	—	4	1	6	—	—	8	—	—	—	34	—	3	—	5
Pr. George's	34	—	1	—	2	1	8	—	—	17	—	—	—	14	—	1	—	5
Calvert	5	—	—	4	—	—	—	—	—	2	—	—	—	1	—	—	—	—
Charles	4	—	—	—	—	—	2	—	—	1	—	—	—	1	—	1	c-1	—
Saint Mary's	1	—	—	1	—	—	1	—	—	4	—	—	—	—	—	1	—	—
Cecil	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	3	—	1
Kent	4	—	—	—	—	—	1	—	—	7	—	—	—	—	—	—	—	—
Queen Anne's	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Caroline	1	—	—	—	—	—	—	—	—	—	—	—	1	3	—	3	—	1
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	c-1	2
Dorchester	2	—	—	—	1	—	4	—	—	1	—	—	—	2	—	—	—	2
Wicomico	9	—	—	—	1	—	1	—	—	—	—	—	—	3	1	8	—	1
Worcester	2	—	—	—	—	1	—	—	—	—	—	—	—	3	—	3	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	1	—	4	—	2	—	—
Total Counties	318	0	37	12	70	5	41	0	0	86	0	1	11	122	2	59	—	49
Baltimore City	235	3	12	24	8	3	67	1	0	125	0	0	12	119	11	628	c-2	37
State																		
Jan. 2–29, 1953	553	3	49	36	78	8	108	1	0	211	0	1	23	241	13	687	—	86
Same period 1952	391	4	24	38	1582	9	116	2	0	97	3	4	17	205	13	507	—	52
5-year median	375	8	19	—	260	8	152	1	0	129	1	4	90	181	81	540	—	69
Cumulative totals																		
State																		
Year 1953 to date	553	3	49	36	78	8	108	1	0	211	0	1	23	241	13	687	—	86
Same period 1952	391	4	24	38	1582	9	116	2	0	97	3	4	17	205	13	507	—	52
5-year median	375	8	19	—	260	8	152	1	0	129	1	4	90	181	81	540	—	69

c = congenital syphilis under 1 year of age
e = infectious encephalitis
m = malaria contracted outside the U. S. A., residence not stated.
t = tularemia
There were 2 positive reports of rabies in dogs, 1 from Calvert County and 1 from Worcester County.

BLUE CROSS AND BLUE SHIELD

THE EMPLOYER AND BLUE CROSS-BLUE SHIELD

R. H. DABNEY*

The Blue Cross-Blue Shield subscriber who utilizes his membership to cover the expenses of his hospital and medical care quite naturally feels grateful to the doctors and hospitals who guide him toward better health. He is grateful to Blue Cross-Blue Shield for taking care of all or part of the bills. He may even be aware of the fact that there is a close relationship between those members of the team that helped him; that Maryland Hospital Service and Maryland Medical Service are, in effect, the agents of the hospitals and the doctors in bringing him the best treatment at a cost he can afford.

But there is another important figure in the background of the picture. It is the businessman: the employer whose cooperation made it possible for the working man to enjoy the benefits of the Plans.

The employer contributed a great deal more to the success of Blue Cross-Blue Shield than his permission to allow membership solicitation to be made on the job and to set up the simple system of payroll deduction of subscription charges on a group basis. The entire group principle is based on his willingness to work with other members of the community health team. Blue Cross and Blue Shield benefits and rates are predicated upon the group principle, namely, that an average selection of risk is obtained which, in turn, means low subscription rates. No health statement is needed, such as would be required if memberships were sold to individuals.

That our very existence is contingent upon the employers cooperation and sponsorship, we all know, but he benefits himself in many ways from Blue Cross and Blue Shield. He derives satisfaction from knowing that his employees are protected against hospital and medical bills. He recognizes that such protection gives the employee more peace of mind and less worry about his personal finances. He knows that it increases the respect of the employee for the company that makes his welfare a part of its personnel policies. He has learned that absenteeism due to illness and poor production on the job are lessened when the employees know that they can afford hospital and medical care at the first symptoms of sickness. In the long run, he finds that it pays in both good will and good business operation to encourage enrollment of his people in a Blue Cross-Blue Shield group. And, finally, looking beyond the doors of his own firm, he sees that he is contributing to the general welfare and good health of people in his community.

* Executive Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

BLUE CROSS, BLUE SHIELD; "INDEMNITY" OR "SERVICE"

OSBORNE D. CHRISTENSEN, M.D., D-OG, F.A.C.S.*

The voluntary hospital is an ever more efficient agent and has come a long way in the last 100 years. Originally conceived as a concentration point for the bedside care of hopeless invalids, few of whom expected to, or did, become rehabilitated; the converse is now so generally true that few expect otherwise.

Although the procedures that the physicians carry out and the medicines and biologicals they use have

* Delegate from Wicomico County to the House of Delegates of the Medical and Chirurgical Faculty, 1952. Vice-President, Medical and Chirurgical Faculty, 1953.

changed radically; the main services which the hospital renders are basically unchanged viz., housekeeping and nursing care for the sick patient, on the one hand; and technical aid to the physician, in his diagnostic or therapeutic efforts, on the other.

The professional nurse is an important part of this complex and her intelligent dispatch of the systems of treatment, outlined by the physicians in charge, determines greatly the nature of the result.

The voluntary hospital was, from the beginning, a charitable and cooperative community answer to the problems of the sick patient; where the facilities could be maintained for all and a nominal charge be made to the users; except the poor. The more fortunate gave freely. The poor, in the real sense, have all but disappeared. Although many are most comfortable, few are sufficiently secure and substantial to consider themselves in the roles of personal philanthropists. The base had to be "broadened," but the hospital patient resisted, and rightly, to becoming the sole support of the hospital. The Blue Cross Plan was a splendid solution—a form of voluntary taxation, mutually levied on the potential users, in groups. The plan solved a difficult situation; but left much to be desired. The public which could prior scarce afford C.O.D. services, and seldom made provisions against the possibilities; now began to gather momentum as Pre-Paid Consumers.

The Pre-Paid Consumer begins his cycle with the natural relaxation of peace and protection; but he has repeatedly demonstrated his ability to develop a healthy, if not a voracious, appetite for things to which he is "entitled." Hospitalization; and its more expensive accessory goods, and services have proven no exception. This has become the kernel of every conference and meeting that is concerned with patient costs; and to postulate that the physicians have effective control and could limit the consumption of these goods and services is sheer fantasy, if not worse!

The lowered mortality and morbidity; and the generally pleasant air in hospitals today, has removed virtually all the deterrents that faced the potential patient; the last barrier is gone, or was, when full pre-payment appeared. To ask the physician to deny the subscriber his use of the Plan is asking him to correct an inherent fault too great; and a fault many physicians foresaw from the inception. The prohibitive cost of automobile collision insurance, except when on a deductible basis, suggests an approach toward an answer to this Pre-Paid Consumer whose appetite will one day exhaust the reserves; in short, nullify the purposes of the entire plan.

So much for the community's cooperative attempt, to find a satisfactory answer to the inadequate home sick-room; and which has evolved the modern voluntary hospital in America, a monument to devotion and service. The Blue Cross is an excellent attempt toward equitable finance, in the field of hospitalization, but some of its features have far reaching aspects deserving close and careful consideration.

The professional doctor and professional nurse are only by association part of the hospital; and in a sense the nurse is the liaison between doctor and hospital; all three rendering a distinct and indispensable service to the patient. The gradual merger of the vision of nurse and hospital has progressed to the point where the nurse, as an individual of professional ability is almost unnoticeable. This is to be deplored. The nurse should be a team member; cooperative but *professional.*

The nurse can hardly recall that her counterpart of a century ago once worked almost solely in patients homes. Not so the physician; his activities in the hospital have only recently become a major, albeit always important, part of the many functions of his profession. He has adapted himself and his patients to the hospital and it to him. He depends on the hospital, from a practical standpoint, but not fundamentally.

As to his services to the patient, they resist definition; and this is the key to a profession. The amount, type, scope and value of those services vary in an infinite number of ways and these are subject to change without notice; according to the giver and the receiver, and countless other factors. The custom of paying a fee for a professional service has long been justly honored as a solution; and no other profession can point to a more honorable record, of service to the needy save, perhaps, the clergy.

We are threatened by some politicians with *Federal* standardization of professional services for medicine; and wooed by well meaning friends and associates to join voluntarily in a Blue Shield Plan, whose aims and principles differ only in degree. This seems harsh but it is, at least, honest. The means

of finance may belong to financiers and planners, but the agreement on the nature of the services, and the fees to be paid, in any given instance, is a matter to be settled between the parties involved—and this is a fundamental to a profession.

This author is concerned with but one issue; it lies between "Indemnity" and "Service" as the basis for payment of pre-paid medical insurance. The indemnity method protects the above defined fundamental and, in no way that is apparent, injures the policy holder. He can readily find treatment at the Service fee levels, *if* these are realistic; all factors being considered, including the momentary economic indices, both general and personal. What sufficient purpose, then, exists, for the profession to catalogue its services and offer them at pre-determined fixed fees? Let us not lose touch with the people. The arrival at an equitable fee must be a cherished privilege and recognized as a responsibility and a trust, of no less importance than the several other great keystones underlying the relationship between patient and physician. The "Indemnity" feature has desirable elasticity and will limit the endless pressures, conferences and debates, through which one group, and then another, will attempt to alter the details of payment, premiums and eligibility in a fixed-fee service plan.

Let us resist the continuation and expansion of the types of plans which catalogue fees exactly, and provide full pre-payment to the consumer. Inflexible to the physicians, taxing the thrifty user in favor of the less scrupulous—the so-called "Service" plans are a long step towards reducing the status of the profession, eliminating the physician as a free agent; and nullifying the value of money as a mode of exchange and a method of saving for future use, the fruits of one's present or past endeavors. Thus, both the subscriber and the physician are injured. The steadily climbing premium costs are mute testimony, and these are but a preview; for the plan administrators can not forever expect the luxury of claims even as low as now! How long will the private patient continue to build and furnish the hospitals while the Blue Cross patient enjoys a maintenance cost basis? How long will it take us to realize that these are not a few of our patients, but soon will be almost all?

Let us leave no stone unturned in a search for insurance against *catastrophe*, either sudden or chronic. This is the insurance every honest citizen wants. Let us, however, stand as a bulwark against signing the public and the profession to a contract which tends to standardize professional fees; must eventually lead to endless bickering between the representatives of the policy holders, hospitals, and professional groups—each anxious to obtain equity; whilst uncontrollable wastefulness makes a mockery of the entire proceedings!!

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1953 MEDICAL ORIENTATION CONFERENCES SECOND ARMY AREA

The Medical Section, Headquarters Second Army will conduct a series of Medical Orientation Conferences for Reserve Officers of the Army Medical Service in the Second Army Area. The meetings will be held in the following cities:

Cleveland, Ohio	14 March 1953
Cincinnati, Ohio	15 March 1953
Philadelphia, Pa.	21 March 1953
Pittsburgh, Pa.	22 March 1953
Richmond, Va.	28 March 1953
Baltimore, Md.	29 March 1953

For further information write to WILLIAM S. SMITH, Lieutenant Colonel, MC Chief, Operations Division Medical Section, Headquarters Second Army, Fort George G. Meade, Maryland.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

OUR FIRST PARTY

MRS. E. ELLSWORTH COOK, JR.*

Now that our first dessert luncheon, fashion show and card party for the Baltimore City Auxiliary is successfully over, I can look back on it with a warm glow instead of a large question mark! Since this

Mrs. J. Carlton Wich

was our first venture into the social whirl, exact planning as to number of tables and chairs, table prizes, the amount of food to purchase, etc., was difficult. Hutzler Bros. who staged our fashion show, said that we must have a minimum of 300 people present to make it worth their while. We optimistically assured them of their minimum and promptly wondered where we could possibly sell that many tickets. Our ticket chairman, Mrs. Edwin H. Stewart, Jr., decided the best way was to contact each Auxiliary member by phone and ask her to be responsible for at least one table. This was not very difficult and everyone worked hard selling tickets!

Mrs. Nathan Needle and Mrs. Irving Taylor, our fashion show chairmen, selected the models for the show from our membership. We purposely chose clothes for various age groups as well as in different sizes so as to make a more universal appeal. Having

Mrs. Newland Day, Mrs. E. Ellsworth Cook, Jr., and Mrs. Ross Brooks

Auxiliary models not only saved us quite an expense, but it also added greatly to our fun. The corsages donated by The Avenue Florists for our models to wear made the evening gowns and our lovely wedding scene complete.

Mrs. Albert E. Goldstein, our President, saved the treasury another expense by securing a donation of Meadow Gold Ice Cream! We are indeed grateful both to the Company and to her because we can still remember how delicious it was. Our dessert Chairmen, Mrs. Ross Brooks and Mrs. Richard Garrett, served the guests ice cream, cake, and coffee,

* Chairman, Committee on Arrangements, Woman's Auxiliary to the Baltimore City Medical Society.

buffet style, which worked out very well. During the afternoon, cokes and chocolate home-made fudge were sold so rapidly that next year the amount of fudge made could be greatly increased.

In the hallway, in an eye catching spot, was a beautifully arranged display of Christmas cards, wrappings, and ribbons. Mrs. John DeHoff and Mrs. Deonis Lupo were responsible for the Christmas table and were delighted at the many sales they made.

Another extra source of income was the raffle of a white cocktail hat. Mrs. John Norton was Chairman of the raffle. Mrs. Norton, one of the pretty models who consented to put on the hat and show everyone how becoming it was, put her hand in the raffle box and promptly drew out her own winning chance!

To compensate to the guests for not winning the hat, Mrs. Robert Berry and Mrs. Arthur Ward distributed numerous door prizes that thrilled their winners. The Bridge Chairman, Mrs. W. Kennedy Waller, is still receiving congratulations on her choice of such a novel bridge prize. It was a glass bottle with directions and ingredients for making several kinds of salad dressings.

One of our most important 'shots in the arm' was the valuable publicity Baltimore's two Newspapers gave us. Through the efforts of Mrs. J. Carlton Wich, the Benefit Publicity Chairman, there were two articles in each paper and two pictures one of the committee and the other of several models in the News Post.

Last, but not least, we were very fortunate in having the Medical and Chirurgical Faculty Building as the setting for our party. Not having to go to the expense of renting a room large enough was a primary factor towards our success. We also felt, sitting there among the portraits of famous doctors, that we were almost as welcome and as at home as they, at 'Med Chi'!

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SECOND ANNUAL PEDIATRIC SEMINAR*

Sunday, April 12, 1953

10:05–11:00 "Immunization Procedures in Pediatrics"
DR. AIMS C. MCGUINNESS
Dean, Graduate School of Medicine
Assistant Professor of Pediatrics, University of Pennsylvania

11:00–11:30 "Discussion"

11:30–12:30 "The Common Respiratory Infections in Pediatric Practice"
DR. WALDO E. NELSON
Professor of Pediatrics, Temple University, Philadelphia, Pennsylvania

12:30–1:00 "Discussion"

1:00–2:30 Lunch

2:30–3:30 "Emotional Problems of Children seen frequently in Pediatric Practice"
DR. LEO KANNER
Professor of Psychiatry, Johns Hopkins Hospital

3:30–4:00 "Discussion"

4:00–5:00 "Common Urologic Problems in Children"
DR. MEREDITH CAMPBELL
Professor of Urology, New York University

5:00–5:30 "Discussion"

* For additional information contact Dr. J. Edmund Bradley, Pediatric Department, University of Maryland, School of Medicine, Baltimore 1, Maryland.

Ancillary News

BALTIMORE CITY DENTAL SOCIETY

A. BERNARD ESKOW, D.D.S., *Journal Representative*

The essayist at a recent meeting of the Baltimore City Dental Society was Dr. Louis I. Grossman, Associate Professor of Oral Medicine, University of Pennsylvania Dental School. His subject, "Poly-antibiotic Treatment of Root Canals" was quite interesting and informative.

At a later meeting Colonel Joseph L. Bernier, D.C., Chief, Dental and Oral Pathology Section, Armed Forces Institute of Pathology, was the speaker. He discussed "Oral Diagnosis with Particular Reference to Pre-Malignant and Malignant Diseases," and many complimentary remarks have been received about his lecture.

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First All-Faculty Dance!

A STATE-WIDE BALL WILL BE PART OF THE ANNUAL MEETING PROGRAM

April 27, 1953

Make reservations now for the "Evening in Paris" Ball to be held on Monday, April 27, 1953, from 9 until 1 A.M. at "The Alcazar" and sponsored by the Woman's Auxiliary to the Baltimore City Medical Society.

Black tie. Be a "Parisien," be a Patron and be THERE!

An early return of the form below will be appreciated. Please make checks payable to the Woman's Auxiliary to the Baltimore City Medical Society and mail to:

MRS. E. ELLSWORTH COOK, Jr.
2431 Maryland Avenue
Baltimore 18, Maryland

Please send me_____tickets at $3.00 per person, including tax.

Also enclosed please find $_____for the Patron List, at a Two Dollar Individual Minimum.

NAME_____

ADDRESS_____